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Transformation: Change for Improvement in Healthcare

Doctorate in Professional Studies by Public Works

Context Statement

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M00423682

May 2013

Doctorate in Professional Studies by Public Works: Context Statement

Middlesex University

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The views expressed in this research project are those of the author and do not necessarily reflect the views of the supervisory team, Middlesex University, or the examiners of this work.

Glossary

Clinical Commissioning Groups (CCG): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Healthcare Commission was a non-departmental public body sponsored by the Department of Health. It was set up to promote and drive improvement in the quality of health care and public health in England and Wales. Abolished on 31st March 2009 and its responsibilities in England broadly subsumed by the Care Quality Commission.

NHS Institute for Innovation and Improvement (NHSI): an ‘arm’s length’ body to support innovation and improvement in the NHS (2005–2013).

‘Plan Do Study Act’ (PDSA)

The perception of this cycle came from Walter A. Shewhart (1931), who created the PDCA cycle. Dr W. Edwards Deming popularised it and later modified PDCA to ‘Plan, Do, Study, Act’ (PDSA) (Deming 1994), because he felt that ‘Check’ emphasised inspection over analysis.

You can use plan, do, study, act (PDSA) cycles to test an idea by temporarily trialling a change and assessing its impact. This approach is unusual in a healthcare setting because, traditionally, new ideas are often introduced without sufficient testing.

The four stages of the PDSA cycle:

Plan—the change to be tested or implemented

Do—carry out the test or change

Study—data, before and after the change, and reflect on what was learnt

Act—plan the next change cycle or full implementation.

Practice Based Commissioners (PBC)

Practice Based Commissioning was a government policy (April 2005) which devolved responsibility for commissioning services from Primary Care Trusts (PCTs) to local GP practices.

Under Practice Based Commissioning, practices were given a commissioning budget which they had the responsibility for using in order to provide services. This involved:

- identifying patient needs
- designing effective and appropriate health service responses to those needs
- allocating resources against competing service priorities.

Practice Based Commissioning transfers these responsibilities to primary care clinicians—effectively to local GP practices, with the PCT acting as their agent to procure services.

Statistical Process Control (SPC) is a method of quality control which uses statistical methods. SPC is applied in order to monitor and control a process.

Trust: A National Health Service Trust provides services on behalf of the English NHS and NHS Wales.

The Trusts are not trusts in the legal sense but are in effect public sector corporations. Each Trust is headed by a board consisting of executive and non-executive directors, and is chaired by a non-executive director.

Opening Reflection

Working in the NHS culture has required focusing on ‘doing’ things, making things happen as quickly as possible, as the context is driven by huge budgetary concerns. Targets have to be met and measurable outcomes designed and applied to short deadlines, influenced by different political agendas acting ideologically or in response to national, regional and global politics. These factors make the context ever-changing. This creates the conditions for change agents to be more engaged with firefighting and reactive changes than concentrated on developing visions shared by all the stakeholders for sustainable change to ensure the future of an equitable high quality NHS. Throughout the course of these public works, what consistently emerged from my reflective engagement was the value of people and people as an untapped resource, beyond being instruments of processing and delivery.

There are two important considerations in bringing about successful change: the mechanistic elements and the behavioural elements. The mechanistic elements of change are usually the focus in the NHS, for example project management, performance management and reducing waste. However, the behavioural side of addressing change is a neglected area (Keller and Aiken 2008).

Over time I came to understand this as a situation encouraging a culture of addressing the urgent rather than the important; more profoundly, ways of ‘doing’ rather than ways of ‘being’, as described by Heidegger (2000). Maybe it is not just cultural but the way we have evolved. The key issue that Kahneman (2012) talks about is the dichotomy of our two decision-making systems: System 1 is fast, instinctive and emotional; System 2 is slower, more deliberative and more logical. Kahneman delineates cognitive biases associated with each type of thinking and suggests that people place too much confidence in human judgment. System 1, the more instinctive, is great at accessing plenty of ideas, making connections and pulling together a story or ‘best guess’ answer. Often this kicks in first and the more logical system never questions it. In short, we are hardwired to make up information

or stories on the flimsiest of facts. We therefore need to handle this throughout the change process and in our reflective processes.

In the first public work, Improvement Partnership for Ambulance Services, having seen the impact of its use with 'challenged Trusts' I used appreciative inquiry. Appreciation can be lacking in these difficult settings. As the works progressed my thinking deepened and I came to realise that the work of Ganz (2009), along with the values which had arisen in my formative years, had been operating within me at some level and informing my choices. Perhaps one of the greatest challenges of undertaking this programme was extricating myself from the NHS culture so that I could think and feel this engagement with my works rather than just do it. I came to realise that I had become more institutionalised than I initially thought, acknowledging my own habitus.

Mauss (1934) defined habitus as those aspects of culture that are anchored in the body or daily practices of individuals, groups, societies, and nations. It includes the totality of learnt habits, styles, tastes, and other non-discursive knowledge that might be said to 'go without saying' for a specific group (Bourdieu 1990, pp. 66-67). I think this has some similarities with Schein's (1992, p. 12) definition of culture as:

A pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to these problems.

Bourdieu (1993) describes habitus as a reference to lifestyle, the values, the dispositions and expectation of particular social groups that are acquired through the activities and experiences of everyday life. So I had to reflect hard in an objective manner to distance myself from my habitual way of seeing the world in which I work: my typical behaviours within my context.

I do not claim through this critique of my works to have become an expert on Ganz, appreciative inquiry or be an amateur philosopher, but to have had the opportunity

to reveal their influences and to encourage in myself a more conscious engagement with works and ideas that support the whole human being. I believe this is captured in the notion of a way of being. Heidegger (2000) maintains that our way of questioning defines our nature. He argues that philosophy, western civilisation's chief way of questioning, has lost sight of the being it sought. Finding ourselves 'always already' fallen in a world of presuppositions, we lose touch with what being was before its truth became muddled. As a solution to this condition, Heidegger advocates a return to the practical being in the world, allowing it to reveal, or 'unconceal', itself. Heidegger opines that 'questioning is the piety of thinking' (cited by Haar 1993, p. 107).

In these works I have 'unconcealed' much to myself and have learnt a different kind of questioning.

Transformation: Change for Improvement in Healthcare

All improvement is change, but not all change is improvement. (Goldratt 1990)

Summary of Public Works

I decided to embark on this doctoral journey because it would give me the opportunity to explore some of my public works critically and help me articulate my voice of praise and dissent in an informed and measured way about how and why our National Health Service (NHS) stumbles and occasionally runs into the future. It has been, so far, a remarkable journey and a remarkably challenging one. At times I have had to question deeply the optimism I have clung to, but I am proud of what I have achieved and nearly achieved. I am proud to have acted in a way that I approve of in myself, in that I have worked to ensure the sustainability of the NHS and the people who work in it for the benefit of us all: we are, and know others who are, all patients at some points in our lives. At this stage it is important to me and to anyone who reads this to know what has influenced my choices to work in the NHS for so many years. It has given me some valuable insights to have tried to answer what has worked, what I have learnt in approaches to improve the NHS and some reflections on what hinders improvement in the NHS.

Working in healthcare for over 26 years, I have become experienced and developed skills in healthcare improvement, change facilitation and service transformation. I am passionate about improving England's NHS, which is often taken for granted and often criticised, sometimes fairly.

I started improving services through instinct and then discovered there was a world of theory and practitioners and much to do to support the NHS in developing these skills. The challenge about improvement is that it is about change.

People resist 'change'. Human beings are programmed to mistrust change, as it usually means turmoil and an alteration to their patterns of behaviour.

Improvement relates more to what human beings are very good at, which is adaptation. Improvement has a different temporality—it implies slower adaptive processes, a step at a time. Change implies or is perceived as something swift and frightening and to be regarded as suspicious. Part of what does not work in current approaches is there are so many changes that people have no time to adapt.

Further improvement can be seen as a criticism of past work, which is why it is critical that the improvement is driven by those involved in the changing processes. Improvement is about empowerment and enlightenment. This is reflected in a range of works, for instance Kanter (1983, 1989, 1992, and 1999), Kotter (1995, 1996), Argyris (1990), Quinn (1978), Tarplett and McMahon (1999) and Schein (1992, 2013).

This statement is a critical engagement with my role as a senior practitioner in the NHS in England. The following is a selection of my public works, chosen with the intention of extracting the threads of learning from these experiences. I like the idea of 'pragmatism' as a philosophical tradition, centred on the linking of practice and theory (Bertilsson 2003). It describes a process where theory is extracted from practice, and applied back to practice to form what is called 'intelligent practice'; this is what I am hoping to demonstrate.

The works commence in 2003 when I undertook my first role working at national level. This is when, with a new knowledge base and mind-set gained through the study of my Masters (in leading innovation and change), I branched out from local improvement into endeavouring to support improvement at a national level. For each role I undertook at national level I felt underprepared, digging deep for resources and confidence, seeking knowledge, advice and support from all areas (colleagues, books, journals and new contacts) to address the unique challenge before me. All the time I was drawing on what I realised was implicit knowledge accumulated from a variety of influences and experiences before 2003.

The chosen works best illustrate the journey that I have made and how the knowledge gained through each programme of work influenced the next programme of work.

1. **IPAS**—Improvement Partnership for Ambulance Services (2003–2005)
2. **No Delays Programme**—18-week waiting time target (2006–2008)
3. **iLinks**—supporting NHS Trusts to improve (2008–2009)
4. **Leading Large-scale Change Programme**—supporting others in delivering large-scale change in the NHS (2011–2013).

The works are unique or distinctive in a number of ways:

- They were ‘firsts’; no-one had trodden this path before. For example, the Improvement Partnership for Ambulance Services was the first national programme to support the transformation of ambulance services. Their challenges were many and the expectations of the Department of Health high.
- They were ambitious. For example, the No Delays Programme addressed the 18-week waiting time target. In the years before the target was set, between 84 and 99 per cent of patients waited more than 26 weeks; it was not recorded how long they waited in total (Martin, Jacobs, Rice and Smith 2003; NAO 2001). NHS staff anecdotally shared that the wait was up to three years for some procedures.
- The target meant that the average waiting time would have to be approximately seven weeks, in order to achieve a maximum of 18 weeks from GP referral to treatment.
- They had to aggregate learning from different fields and sources in order to address the challenge. This required me to be interdisciplinary in my approach to problematising and resolving issues.
- They occurred at a national level. In other words, they were large-scale change and were widely spread across geographical boundaries, multiple

organisations, or multiple distinctive groupings (e.g. doctors, nurses, managers and social care workers). They were deeply challenging to current mental models and ways of thinking, that is, they felt uncomfortable and evoked some resistance from others because they were different from the usual practice, by broadly impacting on what people do in their lives or in their time at work and requiring co-ordinated change in multiple systems.

Initial reflection on these works led me to identify several recurring themes:

- service transformation/transformational change
- healthcare improvement
- large-scale change.

These are summarised in Table 1 below:

Themes	Delivered; Service transformation/ Transformational change. To improve healthcare	Delivered; Large-scale change	Key activities
Programmes of work;	Improvement Partnership for Ambulance Services	Yes	Leadership development and sharing good practice. Support for challenged organisations.
	No Delays— Addressing the 18-week waiting time target	Yes	Design of a website to integrate data, how to use it and linking in relevant service improvement tools to the data analysis to improve flow and reduce waiting times.
	iLinks—Organising for Quality and Value (O4QV)	No	Ultimately: development of an ‘improvement science’ education programme to deliver small-scale change.
	Leading Large-scale Change Programme	Yes	Design and delivery of an education and coaching programme to deliver large-scale change.

Table 1: Summary of public works and their themes

My approach to critical engagement is that of an abductive pragmatist, which is congruent with both my personal and professional way of interacting with the world. I am so used to reflecting on everything I do that it has become a way of being for me. Critical engagement is not just asking the questions but knowing the right questions to ask and using what emerges in response to inform the next stage. My approach combines personal reflection, debate and discussion with others and reflection on the formal evaluations of the programmes of work I have delivered. I have often been described as a pragmatist in the sense that I can translate the theory into practical use. Whilst I like very much to explore theories, I am less interested in the abstract of learning than in its practical application. Pragmatism is a philosophical movement asserting that the meaning or truth of a concept depends on its practical consequences. The founder of American pragmatism was Charles Sanders Peirce (1839–1914), who introduced the mode of inference of ‘abduction’. Abduction, Peirce says, ‘is closest to reality for we cannot form any judgment at all if it were not for the power of abduction; now we see what we did not see before’ (cited by Bertilsson 2003). Peirce used it to denote the only truly knowledge-extending means of inferencing, so he claimed, categorically distinct from the normal types of logical conclusion, namely deduction and induction.

Peirce’s own well-known example is about beans:

Minor premise: These beans are white.

Major premise: The beans in the bag are white.

Result: The beans come from this bag.

Often the ‘abductive judgment comes to us like a flash. It is an act of insight, although of extremely fallible insight’ (Peirce, cited by Bertilsson 2003). Bertilsson (2003, p. 6) states:

However trivial as this ‘semi-logical’ operation may seem, it nevertheless has wide consequences. What kind of inference are we really dealing with? It does not have the same logical firmness as deduction, where the result must be true

if the major and minor premises are true. The act of insight that 'the beans are from this bag' may not be true at all, as someone else outside our purview might have put them there. Nevertheless an abductive inference strikes us often as a reasonable (working) hypothesis. An abductive inference gives us a clue to reality, but it always remains on the level of a maybe. And if we look seriously into the premises which guide both deduction and induction, we will soon see that abduction plays a crucial role in each: it informs the minor premise in deduction as it informs the rule of induction.

Reichertz (2009, p. 7) describes it as:

in every sense, a means of inferencing. It is precisely in this quality of being a 'means-of-inferencing' that we find the secret charm of abduction: it is a logical inference (and thereby reasonable and scientific), however it extends into the realm of profound insight (and therefore generates new knowledge). The secret charm of abduction lies straight in this kind of inference-being: abduction is sensible and scientific as a form of inference; however it reaches to the sphere of deep insight and new knowledge. Abduction is intended to help social research, or rather social researchers, to be able to make new discoveries in a logically and methodologically ordered way.

This demonstrates that my considerable and diverse experience in my role as someone commissioned to improve aspects of the NHS, reflecting on what worked well, what did not and my observation of contextual impact, is a valid form of learning about how to improve healthcare services. This learning gathered along the way has shaped the support I have provided as I have moved from one programme to another.

Formative Influences

Growing up in humid places where your clothes stuck to your damp body, I was taught by my father, Professor of Economic Geography, passionate about supporting developing countries, that we are all equal. I lived in a home with guests and friends from every conceivable nation, constant visitors, happy to play with this little white girl.

My father chose to send us to local schools in these countries and not boarding schools in England, as his fellow expatriates did, as he believed in the value of living in different communities and the learning it brings you. He was passionate about the education of his three daughters and that they should be able to be autonomous not dependent on a man for survival. This was in the early sixties when woman lecturers were paid less than their colleagues. I know that his values and interests shaped me.

These travels meant I learnt the similarities and the differences between peoples.



This is a pot given to me by its maker, a 10-year-old Fijian boy who was the same age as me. He had never seen a white person before, and I can remember him trying to wriggle away in embarrassment as his mother brought him to meet me. I really felt his embarrassment as a 10-year-old myself—similarities.

Living in Nigeria, every time I went into the supermarket with my mother we held hands, our fingers linked we passed rows of beggars. But the beggars had no fingers, sometimes missing limbs as a result of untreated leprosy due to a lack of education and healthcare—the differences.

We came home to the UK and I married lovely Andrew. We enjoy travelling. Years ago we were visiting Lisbon with its beautiful architecture and unique museums. Lisbon's cobblestone pavements are amazing works of art. The pavements can be quite a distraction as you walk around the city, featuring abstract figures, store logos, or traditional or modern designs. But, squatting on a beautiful pavement, was a man who was not beautiful, with a horrendous facial disfigurement, begging, begging because his lack of treatment meant no-one would want to employ him.

I squeezed Andrew's hand very hard and hissed, 'never, never will I complain about paying taxes'. The taxes we all complain about paying, which support the NHS many of us complain about and all of us use; the NHS where treatment is free, so we will never be one of those beggars I have met.

The above influences have helped shape the way I think, my behaviour and how I decide on a course of action.

Professional Influences

I did not commence the career I had planned. The demand for a grade 'A' for Chemistry A level for a degree in landscape architecture tripped me up, although gardening remains a passion.

I started my career in healthcare by taking a degree in podiatric medicine, chosen without passion, a suggestion by my mother in an objective conclusion that it offered a range of choices: NHS, teaching or possibly private practice. I did well, winning most of the prizes and gaining a distinction. I had not done well in my A-levels. The diversity and number of schools I attended may have been a factor, but I had felt a huge failure and strove very hard at university.

University was largely what I expected, but working in the National Health Service (NHS) was not.

I was surprised to find myself working in village halls in dirty surroundings with colleagues who (despite three-year waiting lists) thought it acceptable to finish work at 3.30pm. For my first week of employment I spent a few days with the 'boss', a man who had built up the service and built an orthotics lab with his own hands in his own time in a room in a community hospital, showing a real passion. Yet he told me to see six domiciliary patients in an afternoon. I asked what I should do when I had seen them, and was told, 'go home'. I quickly realised that if you planned your routes well you could easily do ten to twelve patients and finish at

5.00pm, but it was not a fact that anyone wanted to discuss. Collusion was seen as the better offer. My foot-care assistant gave me some advice: see as many patients as you can, then take a regular afternoon or day off as long as you do the six per afternoon average. I was speechless.

Practitioners were largely based in the same clinic, working the same geographical patch. My clinic was spotless, the stock rotated and patients were happy. Then I went to provide cover in another community clinic where the filth was appalling. I can remember telling my foot-care assistant that we would first scrub the place clean and then see the patients, although we would run late. She groaned but agreed, so we rolled up our sleeves and scrubbed the place clean, disposing of out of date and dirty stock. I apologised to the patients then welcomed them in.

So, improving healthcare started in my first few weeks in the NHS, driven by a natural instinct for cleanliness, order, high standards, and a desire to provide the best possible care I could with an expectation that others did the same. It had its rewards: patients loved you, you really made a difference to their lives and many of them showed their gratitude. Ex-clinicians from all professions often describe the contact with patients as something they miss, and I suspect this is one of the reasons why.

I remember one domiciliary patient I had been visiting in his home for 12 months, a widower with no children. We both knew he was very ill. At each quarterly visit he would press me to share a whisky with him, and I would decline. Then on one visit he asked again, I declined, but he asked again and squeezed my arm. We both knew this was our last meeting as he was now very ill. He poured out a huge whisky, so I shared a final whisky and knew I had done the right thing. I then drove to the health centre and spent the rest of the afternoon trying to sober up. If any member of my team had told me of this tale I would have admonished them for being foolish. But even now I still feel very emotional about it and know that doing the right thing is not always the proper thing. This produces a weird tension in my mind as I go about being proper everywhere.

A few years later my passion for doing the right thing for patients meant I had the courage to do what others did not, and to dismiss or move on staff who were not competent to practice. Others hesitated, but it was important to me to do the right thing and not the easy thing. Reflecting on the role of leadership, 'The only thing of real importance that leaders do is to create and manage culture', argues Schein (1992, p. 5). To those who hesitated I asked, 'would you want them treating your family?' I had assumed healthcare was always delivered to a high standard and that that was the norm. It was not. It requires extra effort in a busy environment and a strong degree of conscientious behaviour and, for a variety of reasons, this is not for everyone. In some cases a lack of education results in poor practice, or in an inability to assimilate, retain and utilise the information, or in poor systems. Finally, it is culture—what is deemed to be the norm and acceptable allows poor practice to be acceptable. The recent Mid-Staffordshire enquiry (<http://www.midstaffsinquiry.com>) is the most recent evidence of that in the NHS.

People often comment on my energy, drive, passion and high standards. I used to say I was simply conscientious, but I think it is more than that. I would say I like a challenge and I do, but why? I think it is because I want to be the best, to win and conquer. Second-best is not great, perhaps because I have reasonable self-awareness and I know I am not the best in so many ways but appreciate that simple graft and drive can get you to the next rung. Then it all falls apart due to my naivety. My strong values of truth and fairness struggle with the real world of organisational politics—'it's not what you know but who you know'. A disdain for organisational politics is a liability: 'Those who lack political astuteness more often blunder in trying to mobilise others to their cause because their attempts at influencing are misdirected or inept', states Goleman (1998, p. 162). Another perspective was this feedback: 'If there is any criticism of Julia in her management role, it is only that she expects other managers, at whatever level, to also operate at this high standard'.

Yet I also know I have been an inspiration to many staff. Bennis and Nanus (1997, p. 20) state: 'Managers are people who do things right and leaders are people who do the right things'. Transformational leadership was identified as a leader's ability to influence others without using authority: 'leaders and followers raise one another to higher levels of motivation and morality' (Burns 1978). Past feedback indicates that I lead staff well, but manage less effectively upwards. The journey has been painful as some of my managers have felt threatened or judged by me and have responded aggressively or in bullying mode. Yet still I strive to do the best to support our NHS—free at the point of care—that is such a great liberator of people that many of us in the United Kingdom take it for granted. A drive to provide better services may also be linked to my personality type, as defined by Myers Briggs, 'E.N.T.J.' (Myers 2000). I score highly on 'T' thinking: structuring my decisions through objective balance; emphasising logic and reason, truth and fairness.

My career progressed from heading up a service to a general manager role, increasingly being given what the services define as the 'poisoned chalice'—transforming the services in an average of six months, with robust support from the staff involved. However, not all my line managers were fans as I challenged and intimidated them too much, with my lack of political astuteness. At a local level my career culminated in being Director of Primary Care, where I was good at my job and delivered good services. It came crashing down in a governmental restructuring of the NHS in 2002, as I was not a nurse, a stipulation for the same post in the new (smaller) Primary Care Trusts (PCTs), as the post doubled up as the nurse board member.

These challenges in one's life provide the opportunity to step back and review, if one lifts oneself out of the inevitable grief, but it takes time. However, the NHS inefficiencies that needed addressing were still a driver and my holiday in Lisbon acted as a useful reminder of what was precious. I took the plunge and tried for a national post. My then recent Masters in Leading Innovation and Change had generated an interest in leadership so, to use what I had learnt in my Masters, I applied to work for the Department of Health in the Modernisation Agency in the

‘Performance Improvement Team’ as an Associate Director for Senior and Middle Managers Leadership and Skills Development in challenged Trusts (my dissertation had focused on leadership development). I developed a passionate interest in this when the evidence I found showed that many programmes of development were ineffective. The findings of my dissertation identified that a course may be perceived positively and any method of personal support (where available) was valued, but that the most crucial element was the impact of the line manager. The literature review identified that a leadership development programme that extracted participants from their context and did not relate to it would be unlikely to influence organisational change, although it might result in individual development. Recommendations were made that would improve the effectiveness of a leadership programme in bringing about innovation and change for an organisation:

There is a need to ensure, before use, that a programme fits with the context of a Trust. An integrated approach involving whole systems is proposed. Pre-selection and assessment with a follow up assessment is recommended to raise the expectation of change and establish an evaluation process. Further, the need for action learning with on-going support in the workplace is recommended to transfer the learning back to the organisation. (Taylor 2003, p. 4)

There it is again: that driver to do what is right and effective. It was a new post and I had been the only applicant without an Organisational Development (OD) background. Other applicants were OD and human resource professionals. It was a bold appointment. It certainly felt ‘in at the deep end experience’ to support organisations in a state of distress and to support leadership development.

My first national role brought about a huge change in my perspective on topical issues. I moved from a parochial perspective working at a local health economy level to understanding the influence of the Department of Health on NHS support programmes of work, which were in turn influenced by Ministers and politics. It was a revelation to find that policy was not always based on facts and figures with robust informed debate but by individuals’ agendas, sometimes in the heat of the

moment; by personal preferences that may have had an emotional rationale rather than a logical one; or by the uninformed.

However, using what I had learnt from my Masters about the importance of developing leadership in context I quickly found that what I had been requested to do (design a leadership development programme that these leaders could attend away from their challenged organisations) was not appropriate and a different approach was needed that was specific to their context.

As this work was being shaped, I was unexpectedly asked to be a 'client manager' for a zero-starred Trust.¹ This role required supporting the delivery of an assessment of the issues within the Trust (diagnostic), designing a support package and being the key liaison for the Chief Executive Officer (CEO) and executive team, and providing recommendations to the Strategic Health Authority responsible for the Trust's performance management. This would include recommendations about the viability of the current CEO's role. The Trust happened to be an Ambulance Trust; there was an absence of experience of working with Ambulance Trusts in this 'turn-around team', as we all had experience of working in healthcare provider organisations. Another 'in at the deep end' experience gave me the opportunity to implement appreciative inquiry (Evans Peterson 2004) as a critical part of our diagnostic of the Trusts in order to ensure the intervention was a positive one for the staff, who already felt very fearful. Searching for the positive good things (what was going well and building on it) in a troubled organisation had a positive impact on the fearful and vulnerable individuals and organisations I was working with. Rather than 'giving up', the staff in these challenged organisations felt empowered to address their own problems; 'we can make it better'. I expand on the appreciative enquiry approach—accentuating the positive in the first public work, the Improvement Plan for Ambulance Services.

¹ Zero-starred Trusts:

http://www.chi.nhs.uk/Ratings/Trust/Overview/ambulance_overview.asp

I found in this role, as in my role in turning around departments, that the answers to the Trust's challenges are found in the resources of many of its staff. They just needed to be unleashed. Staff would be aware of problems but felt unable to do anything or speak out. If you asked their advice on how to improve the situation, my experience was they often had plenty of ideas and energy to improve things, given encouragement and recognition. These organisations also demonstrated a lack of ability to understand and use data and would respond inappropriately to normal variation in activity, so needed to be taught about variation and the theories developed by Deming (1994) as well as his thinking on performance management and performance development. This learning subsequently shaped the programme I designed for Improvement Partnership for Ambulance Services (IPAS) and the element about data and its interpretation became integral to my work.

Only a few months into this role it was suggested I might consider the National Director role for the Improvement Partnership for Ambulance Services (IPAS) that was being advertised. To my surprise I was successful and again was challenging my learning, skills and experiences to the limit—another 'in at the deep end' experience with much to learn that I will reflect on in detail later. My nine months of working at national level helped, but here I had a reduced cushion from the centre and the closer proximity to Government Ministers provided an insight into their demands and their decision-making processes. My earlier role as client manager for the challenged Ambulance Trust had given me a glimpse into the culture and workings of this sector. However, being responsible for a national programme of work to be designed and delivered from scratch, for the first time, with only an intermediate level of comprehension of the ambulance service, its context, culture and challenges, was a steep curve indeed.

I drew heavily on my experiences of managing community, children and mental health services and the complexity of handling multiple stakeholders and empowering staff. There was a small budget, and my team was only a secretary and

a business manager but also a 'boss' who was completely different from me. Watching how he operated was a revelation. For example, if I attended a workshop or conference I would arrive on time, leave when it had finished, and would listen hard. It is proper, is it not, and respectful of the organisers and speakers? Not my boss. He would drag me around London, leaping on and off the Tube, running from one conference to another, one meeting to another, not listening to the speakers but networking, pumping hands, catching up, 'squeezing the flesh' as they say. I was astonished. He was generous too, going out of his way to introduce me to people, but in a way he did not care. He would quickly move on in his relationships with no qualms about contacting someone years after they had last spoken to beg a favour or intelligence. To me it felt unethical, almost a 'use and abuse' form of relationship; but it worked, he got things done through others and this way of functioning was an education. I still struggle with it ethically, but I try to network more and reflect on how often I have helped others years after we have been in contact, so maybe others will do that for me, too.

In Conclusion

I am fascinated by the diversity of life; how all the members of my teams doing similar roles have such different lives back at home. Despite the commonalties of roles at work, their past experiences and personalities shape how they respond to their role and how they see the world; how this view, inherited or learnt, can negatively or positively influence them; hold them back or produce positive, confident people. I reflect often on that about myself. I work in the field of 'change' and understanding how to deliver change means having to grasp both aspects of change: the reasoning, rational side and the emotional, creative side; the fear and hesitation and the risk taking; the altruism and the 'what's in it for me' intrinsic aspects.

My observations of myself and of life around me and being up close to change and its impact on people's behaviour leads me to hold a social constructionist view of reality (Easterby-Smith, Thorpe and Lowe 2002): 'reality' is not objective and

exterior, but is socially constructed and given meaning by people. People make sense of the world through interacting and sharing experiences through language. Human action arises from the sense that people make of different situations, rather than a direct response to external stimuli.

In the context of this doctorate, I am clearly part of what is being observed as well as a critical observer. The human interest is a driver for these works, the explanations are aimed at increasing general understanding of the situation through many lenses: my own and stakeholder perspectives in a web of complexity in which change is required to happen, large- and small-scale, which will have implications of which some can be anticipated and mitigated and others not. It is tackling complexity that is the challenge on which success or failure rests. Therefore, this reflection is all about 'understanding' rather than correlation or causality.

In the next sections I will reflect on the four public works I have chosen for this context statement.

The Public Works

IPAS—Improvement Partnership for Ambulance Services
(2003–2005)

No Delays Programme—18-week waiting time target
(2006–2008)

iLinks—Supporting NHS Trusts to improve
(2008–2009)

Leading Large-scale Change Programme—supporting others
in delivering large-scale change in the NHS
(2011–2013)

See summary in Table 1.

The Improvement Partnership for Ambulance Services (IPAS) (2003–2005)

My Role

National Director for the Department of Health Modernisation Agency;
Improvement Partnership for Ambulance Services

Designer and an author.

Context

The Health Minister at the time, Rosie Winterton, announced the launch of IPAS on 23 September 2003. IPAS was designed to be a joint venture between the Department of Health and the NHS Modernisation Agency with the aim of helping ambulance staff to modernise the service and improve the patient experience. The partnership was allocated funding of a million pounds and it was anticipated that the programme would cease by December 2004 (this was subsequently extended to March 2005).

A service level agreement with the Department of Health was established, with the following objectives set out by the Department of Health for me to deliver:

- improved star ratings for the 2002/03 zero and one-star Trusts in 2004/05 performance ratings. Three out of the nine 'one-star' Trusts would have improved star rating for 2004/05 performance ratings²
- availability of leadership development options to all Ambulance Trusts

² Zero Starred Trusts:

http://www.chi.nhs.uk/Ratings/Trust/Overview/ambulance_overview.asp

- positive feedback from course participants
- two Learning Exchange events, to be held in November 2003
- development of a fully-functioning website
- development of specific learning material for Ambulance Trusts to improve services
- development of good practice checklist for Ambulance Trusts.

The Department of Health would undertake a review of the partnership in January 2005.

This was a highly ambitious programme of work. For example, for Ambulance Trusts with the low star ratings² of zero and one in 2002/03, the goal was to raise their performance by 2004/05 by at least one star. However the ratings of the 32 Ambulance Trusts covered multiple factors (**Appendix 1**), influenced by elements that a small central team, with a small budget for a national programme, would have little hope of influencing.

So I had to think hard about how to maximise the resources and impact. My work with challenged organisations had shown me that the difficulties were rarely about structures and processes and much more likely to reflect patterns of behaviour. Therefore, leadership development relevant to their context was a key area of focus. Supporting them to help themselves was the stance I took.

The IPAS Team was tiny for a national programme. I was appointed as Programme Director on the 1st November 2003. An administrator commenced in January 2004 and the Business Manager started in March 2004.

My Methodology: IPAS work streams

In order to meet the objectives set out in the service level agreement, I set out to develop work streams that would:

- offer relevant leadership development options to all Ambulance Trusts
- provide extra support to the challenged organisations
- spread good practice.

Hence, the following four work streams were developed:

- a leadership development portfolio specifically targeted towards the learning and development needs of Ambulance Trust staff (with funding support for the challenged organisations)
- Performance Improvement Networks (PIN) to develop communities of practice
- good practice guidelines around issues that Ambulance Trusts were struggling with:
 - In response to feedback from the two national IPAS Learning Exchanges in November 2003, it was identified that it would be useful to develop best practice guidelines on:
 - commissioning ambulance services
 - control rooms
- IPAS Affiliates recruited to support challenged one-star Trusts not supported by the Performance Development Team (PDT).

Evidence of Impact (See Appendix 2)

The publications produced can be found in **Appendixes 3, 4, 5 and 6**.

The IPAS Model of Work I Introduced

IPAS had limited human and financial resources, and I was expected to deliver in a short time, so I adopted a key principle of collaborative working and co-production meaning that I could 'borrow' additional resources in terms of people, intelligence and also gain ownership of the programme of Ambulance Trusts. I am not sure what inspired this approach but I am sure it was critical to the success of the

programme. I suspect it was my pragmatism; a practical, matter-of-fact way of approaching or assessing situations or of solving problems.

I established the IPAS Steering Board, consisting of a broad cross-section of influential stakeholders. Membership included representatives from the Department of Health Ambulance Policy Team, Modernisation Agency, Ambulance Trust chief executives and the Healthcare Commission.³ These volunteers were able to guide IPAS as to individuals or teams with the appropriate experience and expertise required by IPAS to further its activities or networks, in addition to the information gathered through IPAS networking.

My guiding principle of collaboration and co-production was generated in response to meeting a range of needs: developing rapport, accessing knowledge and resources, demonstrating respect for the wisdom held by the community I was working with and ensuring what was delivered was appropriate for the community. I now know that co-production is an approach that design companies use to ensure their products meet their customers' needs.

Through this principle of collaboration and co-production with ambulance staff and their Trusts, the following key methods of delivery were adopted by me:

- engaging with key stakeholders with the required knowledge, expertise or experience so I could access this intelligence and be guided by their expertise.
- utilising existing networks within the ambulance world, as a fast way both to share and gain knowledge without attempting to start from scratch.
- asking for assistance to fill knowledge/expertise gaps, i.e. by approaching Trusts, Workforce Development Confederations (WDC), Strategic Health Authorities

³ Healthcare Commission was a non-departmental public body sponsored by the Department of Health. It was set up to promote and drive improvement in the quality of healthcare and public health in England and Wales. It was abolished on 31st March 2009 and its responsibilities in England broadly subsumed by the Care Quality Commission.

(SHA), Modernisation Agency teams. This meant being humble and prepared to ask for help and recognise that others had knowledge that could be critical to improving ambulance organisations and the success of the programme.

- using diverse and different methods to gain expertise/contributions, i.e. focus groups for individual activities/events, interviews, documentation, etc.
- taking the responsibility for leading and delivering activities/events that would connect Ambulance Trusts and share expertise, remembering that at the time Ambulance Trusts did not connect but saw the competitive environment, new to the NHS at the time, as a reason not to work together.
- commissioning activities to fill the gaps that collaborative working and co-production could not meet. For example the provision of facilitators for the action learning sets for the ambulance directors of operations.
- utilising free accommodation from Trusts and other organisations to hold training and events, ensuring my limited budget covered as much as it could.

I met all of the IPAS objectives outlined in the service level agreement and delivered the aims set out in the IPAS work streams. Due to my collaborative approach, I received extremely positive feedback from ambulance personnel and from the IPAS Steering Board. I gained some useful learning, too.

My Reflections and Learning

Successes

IPAS had been highly successful in achieving the aims set out for the programme by the Department of Health and the Modernisation Agency. With regards to the service level agreement set by the Department of Health for me to achieve (p. 30), all the objectives had been achieved by September 2004. The work of the programme set out in the IPAS work streams had also been successfully attained and exceeded.

Through activities I developed for IPAS, the profile of Ambulance Trusts has been brought to the forefront and wider health economy organisations are beginning to

realise the important role Ambulance Trusts have in reforming local emergency care. For example, the IPAS 'Driving Change' event and publication provided the first national debate on commissioning of emergency and non-emergency ambulance services involving all the major stakeholders—Ambulance Trusts, PCT lead commissioners, Acute Trusts, SHAs, WDCs and emergency care network leads. As Professor Sir George Alberti stated, 'One of the big achievements of IPAS is to bring people together to create a more uniform improvement culture, to share experiences and to lead to a much more rapid integration of the ambulance service into modern emergency care' (2004).

In stark contrast to a past culture of Ambulance Trusts working in isolation from each other, a culture of networking and sharing good practice had been promoted through IPAS events, the IPAS PINs communications/publications and guidance documentation. **(Full detail of the work programme can be found in Appendix 2.)** Ambulance staff welcomed this approach and commented on the advantages of discussing and sharing various approaches to issues they all faced. This was particularly evident in the IPAS Senior and Middle Managers Leadership Development Programme evaluation (**Appendix 7**), where the benefits of informal networking during this residential programme were highlighted. The questionnaire was designed and initially tested by me, then adjusted before further testing by a third party. The semi-structured interviews initially designed by me were then both tested and conducted by a third party, again to reduce the bias of my design, testing and avoiding further bias in conducting the interviews, as informed by Denscombe (1998). Denscombe (1998) recommends the use of serial numbers and coding boxes, but I felt this conflicted with his advice to make the visual presentation as user-friendly as possible, thus influencing response rates. I did not use coding or serial numbers as I considered them alienating. Further, I considered the numbering of questions was potentially off-putting. There were 38 questions, but identifying that number could have discouraged some individuals from completing the questionnaire. Therefore, I numbered the three sections that grouped associated questions in a bordered box. In respect of the layout, anecdotal feedback from the pilot was positive. The importance of appropriate sequencing of

questions, with a comfortable flow from factual general questions to those that become more detailed, is discussed by Denscombe (1998), as it can 'entice or deter the respondent'. The importance of a natural and logical order, comment Gill and Johnson (1997), is that it helps to build rapport and comprehension by the respondent, whilst finding an order that is 'psychologically meaningful to respondents, encourages candour and cooperation' state Polit and Hungler (1991, p. 289) so this was also carefully considered during the design and feedback was sought during the pilot.

Some ambulance sub-communities' leads, for example in the 'Patient and Public Involvement' and 'Patient Advice and Liaison Service', planned to self-sustain the informal and formal networking they forged at the IPAS 'Patients Driving the Service' events. This approach of connecting people for support and to share learning is not original, but I found it invaluable in this context and used it again and again in all my subsequent work, 'using the wisdom in the room'.

My ability to engage with Ambulance Trust staff was the key to the success of IPAS. Ambulance Trusts had welcomed the support provided by IPAS, which to them had seemed long overdue. As I was requested to focus initially on challenged Ambulance Trusts, this was perceived as threatening and in the early days I was often introduced as the 'woman from the government' by whom they expected to be 'hauled over the coals'. However, the appreciative enquiry approach and supportive style I took meant they felt less need to be defensive and I was more able to help.

I first came across the concept of appreciative enquiry when studying for my Masters, reading Senge (1990) and Schein (1992). Subsequently, in a role where I supported 'challenged' Trusts, I saw colleagues using the approach to great effect. I read about process consulting in Schein (1999), who describes giving and receiving help. Schein recognises that the consultant never knows enough about the particular situation and culture of an organisation to be able to make specific recommendations. He describes where the client and the consultant can diagnose

the situation and develop solutions as a 'helping relationship' (Schein 1992, p. 1). Instead of asking 'what problems are you having', which is a deficit-based approach focusing on the negative, you ask about 'what is working around here', which is an asset or strength-based approach in the field of organisational development. It relates to working in human systems and addressing behavioural elements. In 'challenged' Trusts the whole environment may feel negative, so exploring problems consolidates this. Taking an appreciative enquiry approach builds on the positive and enables staff to build on what they do well and shift to a more positive frame of mind. Watkins, Mohr and Kelly (2011, p. 5) describe that this is an appropriate approach in the modern world to account for the speed of change and the complexity of the environment: 'the concept of "social construction" ... is more and more understood to be causal. We do indeed, create what we imagine together'. Subsequent to my using this approach, Marshak and Grant (2008) published a paper that described new organisation development approaches that had emerged based on constructionist, post-modern and new science premises. They described how 'these include practices associated with appreciative inquiry, large group interventions, changing mind-sets and consciousness, addressing diversity and multicultural realities, and advancing new and different models of change' (Marshak and Grant 2008, p. S7). This reflects my own practice in 2003 when I started using appreciate enquiry; in 2007 I became skilled in designing 'accelerated change events' (large group interventions) and used these as a tool to support change in and across organisations. The 'Leading Large-scale Change Programme' I led in 2011 includes topics such as changing mind-sets (**see Appendices 24 and 27**).

Ambulance Trust staff valued the inclusive approach I had taken to the design and development of programmes, events and other activities to ensure they were meeting the needs of the Trusts and their staff. A relationship built on respect and trust had been forged. Ambulance Trust chief executives commented that they felt that the IPAS support has been all too brief and that it should continue after 31st March 2005.

Before IPAS ended I was keen to ensure that the lessons learnt and the momentum gained towards the modernisation and improvement of ambulance services was not lost and would continue to move forward. Wholeheartedly supported by the IPAS Steering Board, plans were put into place to hand over responsibility for various areas of work and support to key stakeholders, for example the Department of Health and SHAs, to ensure Ambulance Trusts continued to receive support.

I also held a final 'celebration event' in January 2005 to help Trusts and individuals focus on the improvements they had made over the past 18 months and to think about how they could sustain and build upon the improvements post IPAS. Participants of all the IPAS work streams shared their experiences and learning. I have used this concept of a celebration event subsequently; it is both humbling and inspiring to see the impact of the interventions. Sharing the learning and formally celebrating the achievements is a rewarding process for all involved, as the evaluation sheets at the end of these events reveal. It also serves another purpose: the participants fed back that the act of presenting their experiences of the programme enforced a reflection that they might not have otherwise undertaken and this reflection highlighted for them the journey and progress they had made and hence consolidated their learning. In subsequent programmes I build in a form of celebration event as an opportunity for participants to reflect on their journey and consolidate their learning.

Evidence of Public Impact

See **Appendix 8**

Critical Points

This programme of work was a huge challenge for me: my own perception about being able to work in a healthcare sector of which I had limited experience, my ability to design a national programme of work for the improvement of ambulance services, and designing leadership development for staff who had, generally speaking, not been exposed to it before.

Another challenge was working nationally, which meant a huge amount of travelling around the country and having to accept that all meetings happen in London. I discovered how 'London-centric' England is and how parochial Londoners are. London influences government policy. In my view, government is overly influenced by structures, processes and patterns of London healthcare provision, which is atypical of the rest of the country.

I gained credibility and learning by spending time with staff in a range of Ambulance Trusts, giving me an insight into their ways of working and culture. However, a significant outcome was that I developed relationships and these proved invaluable in supporting the programme. Spending time with staff in their own context was not only useful but perceived positively and, in return, staff were more willing to help the programme. This approach of 'getting under the skin' of the challenge was an invaluable experience that I have continued to use. It reflects the Native American proverb: 'Don't judge any man until you have walked two moons in his moccasins'.

My ideas on the nature of the programme were based on experiences of improving services for which I had been managerially responsible and the learning I had gained from my Masters. Was this enough, and how would I enhance this?

Past experiences had shown me that I could take on services about which I knew nothing as there were always plenty of staff with good ideas: 'Often change need not be cajoled or coerced, instead it can be unleashed' (Kelman 2005, p. 6).

It could be said that I was demonstrating interdisciplinary learning, which is the exploration of a relevant issue or problem that integrates the perspectives of multiple disciplines in order to connect new knowledge and deeper understanding to real life experiences (Stember 1991). However, as the experiences are all from healthcare (from different sectors and professions), some might argue that it is intradisciplinary. My perspective is that the diversity that exists within and between

different sectors and professions in healthcare is substantial and provides a fertile environment for new insights to emerge if perspectives can be opened in an appreciative way.

I found that by empowering staff to take action, by unleashing the staff's frustration with the system and providing them with an opportunity to shape their service into one they would be proud of, improvement occurred. Unwittingly, I think I was providing them with an opportunity to develop a vision for their service and their role in it. I later found out this is a critical element for delivering large-scale change (see public work on Leading Large-scale Change Programme). My role as leader in this journey of improvement was to remove obstacles to progress, provide some capacity and some limited resources. This is beginning to sound 'soft and fluffy'— 'empowering staff' and 'releasing their passion'—but it is not. Yes, it requires a certain leadership style. Goleman (1998) describes this style as mobilising and democratic. However, removing some of the obstacles required a 'commander' style. Problem managers and problem staff were addressed through disciplinary procedures, with some resigning and others moving on. I had expected this to be challenging to the bulk of the staff but in reality they were relieved and delighted. They did not like 'bad' managers and felt colleagues who were underperforming damaged the reputation of the service of which they were part.

The IPAS Senior and Middle Managers Leadership Development Programme comprised basic leadership development and associated skills and knowledge, but essentially empowered staff to take charge and start improving services. At the celebration event I randomly selected several participants to share their experiences. I had no idea what they were going to say and many of them had never spoken in public before. They repeatedly described how transformed they were by the experience, how they had learnt that there was another way of managing staff compared to 'command and control', and the impact my empowering approach had had on them and on their staff: 'the man that stands before you is not the man you saw six months ago'. I speculate that the culture within some ambulance services was oppressively chauvinistic, macho and

autocratic. The service strongly promotes from within, so senior managers had typically risen up through the ranks. In other words, those who did well in that environment reinforced it. The target system in place by the government to achieve change was successful in many ways and, unusually, the ambulance service 'Category A⁴ target' had a clinical rationale,⁵ however I believed it created a culture of fearful and stressed managers who became more controlling: stifling empowerment, suppressing innovation and hence inhibiting improvement.

In my engagement with the directors of operations in Ambulance Trusts, I found isolated individuals. They had a challenging role, struggling with Department of Health targets, yet enjoyed no collaboration. I speculated that improvement in the services would be enhanced by them sharing their triumphs and challenges. The establishment of action learning sets (Revans 1983) for these key individuals turned out to be a great success. I had not used this approach before but have continued to use it in many of the programmes I have designed subsequently with great success. It allowed these proud men the space to share some challenges in private, so they did not lose face, and they gained strength from their new relationships.

In many ways I felt this programme had been about relationships and I was simply a broker, as when linking the directors of operations. Similarly, I can remember a challenged Ambulance Trust having real difficulties with the expectations of the multiple local providers of healthcare in the large geographical area they covered, as the whole thing had turned into a 'slanging match' with the Ambulance Trust being heavily criticised by the multiple Acute Trusts they served. But these Acute

⁴ **Immediately life threatening**—An emergency response will reach 75% of these calls within eight minutes. Where onward transport is required, 95% of life-threatening calls will receive an ambulance vehicle capable of transporting the patient safely within 19 minutes of the request for transport being made.

⁵ Healthcare Commission 2005 stated that clinical evidence shows that achievement of the target could save as many as 1,800 lives each year in people under 75 years suffering acute heart attacks.

Trusts were unaware of the impact of their differing demands and expectations on this Ambulance Trust. There were no conversations actually going on and hence no comprehension of the issues and hence the possible solutions. I simply set up a meeting of the key stakeholders and put them all in one room. It came to light that it was the first time it had ever happened. I was not sure what I would do in the meeting, but it transpired I did not have to do anything apart from create the conditions for the conversation to develop, then sit back as they made progress in solving their problems. The importance of getting the whole system in the room to address tricky problems is something that I have advised or used subsequently. I have recently found out it is something Weisbord and Janoff (2007) advocate, stating that all the key participants need to be present in order to agree reform.

I also learnt that you need to prevent individuals from losing credibility, provide a safe environment for them to be able to learn and grow, and you need to consider the relevance of their current context. For example, the directors of operations had their learning experiences and coaching in private in their action learning sets and focused on their live challenges in their context.

Knowledge needed to be taught with the same consideration. I learnt the hard way when teaching Statistical Process Control (SPC), useful knowledge for Trusts to understand when to change processes. See **Appendix 9** for a description of SPC. I made the mistake of 'skilling up' the ambulance middle managers in isolation from their context. The result was they went back to their Trusts but their CEOs had no idea what they were talking about and the SPC approach was squashed. I decided to run the training again, this time for Ambulance Trust chief executives—in private, at their request. They did not want to lose credibility with their staff and appear ignorant. This time it worked. Following the chief executive event, I was asked to run the SPC training repeatedly for Ambulance Trust staff as their chief executives had been made aware of the potential benefits of using SPC. I then organised regional SPC events for Ambulance Trust staff and SPC became an integral approach in many of the Trusts' board papers to review their data, enabling them to take appropriate action for more efficient services.

This was a key learning point for me. I had shared this critical learning about SPC inappropriately, without CEO-backing and to more junior staff than CEOs, which would mean radically changing their board reports, changing their mind-sets on how they responded to their data sets, and moving away from monthly bar charts that could not show trends or variation. Once the CEOs appreciated the value of SPC they were highly supportive. Subsequently, with any intervention I now consider who should know first, at what level they need to know, which might be as simple as the chronological order in which information is delivered, but it is critical to shaping a receptive context for these busy adults to learn.

At the time I knew nothing of adult learning and I did not know that research indicated that adults show specific characteristics within learning situations that, when applied to the development design and delivery of programmes, greatly increase both the engagement and satisfaction of those taking part. Firstly, the learning has to have congruence with their reasons for wanting to learn in the first place. When the motivation of the learner is addressed, adult learners show greater abilities to engage and retain information or skills. Additionally, adults learn most effectively when any new information is linked to what they already know, and those delivering the learning value their pre-existing skills, knowledge and life experiences. This is increased further when attaining the learners' own goals is made possible and undertaken in a timely manner. This can be strengthened further when theory and practice are linked so that learners both understand the information and also put this into practice quickly. For example, they are able to learn a skill close to the time they need to be able to perform it, not months in advance (Knowles 1973/1990). I like to summarise it as:

- meet participant motivations
- be experiential as well as theoretical
- focus on related goal and outcomes
- be relevant to the moment.

Combining didactic learning with service improvement projects running in parallel and supportive action learning sets has become a winning combination in all my work. Originally all done in a face-to-face approach, more recently I have experimented with virtual approaches and found this equally effective on condition that at least an initial face-to-face event takes place.

So I reflect that supporting these services required a mobilising and democratic form of leadership (Goleman 1998); education in a range of relevant skills at the right time; and that challenged organisations can be a ripe 'burning platform' (Kotter 1996). In addition, they required some uncompromising addressing of obstacles; providing capacity (some via training, some via help from experienced able staff); and that small resources and letting the staff do it themselves can bring about a real transformation in services. I could summarise this as partnership working. In this context, I like this definition: A relationship in which we are jointly committed to the success of whatever endeavour, process or project we are engaged in (Oshrey 2007, p. 117).

During this period I was undergoing training to become an executive coach with expert coach Jenny Rogers. I know this affirmed and consolidated my approach to leadership as one of collaboration and empowerment. Seven years later I worked with Professor Marshall Ganz, who researched the approaches used by social movements to bring about change. He states: 'Leadership is accepting responsibility to create conditions that enable others to achieve shared purpose in the face of uncertainty' (Ganz 2010, p. 527). In this role, I think this is what I was doing.

A final reflection: I was working with NHS services described as 'Cinderella' services. In my opinion, these were often neglected (it was 2003 before the first leadership programme was aimed at this service), and staff were underdeveloped from a managerial and leadership perspective. If you want an integrated, wholesome NHS then we need to treat all parts of the NHS with the same care, investment and attention that the hospitals with doctors doing high profile surgery receive. Do not

let parts of the NHS be treated as outsiders or their staff treated as the lowest of the low during the hand-over to Accident and Emergency services. This may be a generalisation, but disregarding some staff (ambulance staff) involved in clinical care has an impact on clinical care. Not all the data relating to a patient is shared, heard or used. Respect for all and investment in all would bring about a more egalitarian NHS with safer care for patients in an environment where the ambulance staff's information is valued, not ignored. All the information about a patient should be valued, regardless of source.

My Learning in Summary to Myself

Co-production and collaboration, that is, partnership working, is an effective model of working. Leaders have a critical influence so it is necessary to consider them and their needs when designing developmental programmes. Providing mechanisms for action learning, reflection and learning in a safe environment is an effective approach in developmental programmes. When addressing 'system' challenges, it is essential to involve all stakeholders and use the wisdom in the room when supporting staff. There are many kinds of leadership: here, a collaborative approach worked well.

No Delays Programme: 18-week waiting time target (2006–2008)

My Role

National Programme Director for the No Delays Programme delivered by the ‘arm’s length body’, the NHS Institute for Innovation and Improvement (NHSI). Producing the web-based tool, the ‘No Delays Achiever’, and a range of publications and support.

Designer, an author and editor.

‘This is unbelievably clever’

Imperial College (2007)

Context

This narrative is about the development of a national tool to support the transformation of access with the National Health Service in England.

The NHS Plan (Department of Health 2000) set out an aspiration of a maximum three-month wait for any *stage* of treatment by 2008. The NHS Improvement Plan (Department of Health June 2004) set out an ambitious new aim: ‘By (Dec) 2008 no-one will wait longer than 18 weeks from GP referral to hospital treatment’ (Department of Health 2004, p. 28). This was a massive service transformation for the NHS. Typically, for many procedures the existing wait was up to three or four years. It clearly had implications for healthcare improvement and was a large-scale change requiring a mind-set shift for both patients and staff.

However, if waiting times were to be monitored there would have to be the means to measure how long a patient waits. This was a major challenge. In January 2006 the Department of Health invited applications for 'early implementer sites'. Critically, the focus of the work of these volunteer Trusts was on the measurement of how long a patient waits, as this was unknown since existing data sets focused on aspects of a patient's journey and not the whole journey from GP referral to treatment. This work was not focused on how to work with the data to reduce waiting times. Using data to reduce waiting times focuses on reducing or eliminating unwarranted variation across the system that does not add value in a process, and Statistical Process Control is the tool to reveal this. See **Appendix 10** for an extract from the Department of Health letter, Director General of Access (2005).

With only two years to go before the target had to be reached, at last there was a focus directed by the Department of Health on the data collection challenge that had to be addressed before NHS staff could even see where they had to focus their attention to address their waiting lists. It was essential to measure how long patients were waiting. As LeBouef (1985, p. 109) stated, 'The things that get measured are the things that get done', so SHAs and the Department of Health could start monitoring waiting times and performance manage. The focus was on the 'what', but not the 'how'.

In spring 2006, the NHSI was commissioned by the Department of Health to provide support to address the 18-week challenge. A small team was established, led by me. There was no time to waste while the NHS IT systems caught up with the challenge of how to measure how long an individual patient waited and, importantly, how this data could be used to assess the variation in the system and reduce it in order to reduce waiting times.

Although commissioned by the Department of Health to 'provide support', there was no direction, as no-one had any idea how to address the challenge. This would be a shift in culture and required access to data and a skill set to improve services

so patients waited less. However, surveys I designed and conducted showed NHS staff did not know how to find and access service improvement tools or use data to work out waiting times for patients, let alone interpret the data and then link it to the next steps to take in terms of improvement approaches.

Creativity and innovation skills (Plsek 1997; de Bono 2000) were used with my team to come up with a range of ideas, for example a 'patient journey analyser' using existing data that could be accessed by NHS staff, and publications on how to reduce waiting times and access to instructions of various service improvement tools. These ideas were disconnected until I came up with a proposal for a website that could integrate data, diagnose and then link to the relevant service improvement tools. We tested various prototypes with the NHS to deliver finally the 'No Delays Achiever'.

The rationale for the approach was influenced by research by the King's Fund (Appleby et al. 2004) which identified that both the availability and understanding of data were core characteristics of hospitals with demonstrable successful and sustainable management of waiting times. The experience of national service improvement initiatives, such as the Cancer Services Collaborative, also identified the availability of data as being critical to the success of service improvement (Cancer Services Collaborative 2006; Department of Health 2006).

The need and use of data for service improvement is self-evident, as Goldratt (1990, p. 10) stated: 'All improvement is change, but not all change is improvement.' Berwick (2003, p. 449) built on this: 'All improvement is change, but not all change is improvement, therefore the model for improvement includes measurement—a way to know which changes help...'.

Also, I spoke to experts, who told me: 'Our analysis indicates most queues within the NHS are relatively stable, suggesting that capacity and demand variation are the cause' (Silvester and Walley 2005a, p. 14).

There are three potential reasons for waits:

- demand exceeds capacity. However, if this were the case then waiting lists would continue to rise without control. There was no evidence of this; in fact, very few waiting lists behave like this.
- there are mismatches in capacity and demand (caused by variation). There was evidence to support this, e.g. 'busy shifts' versus 'quiet shifts'.
- making patients wait longer without realising it, by batching and ring fencing our work. In our work with Trusts there was evidence to support this, for example reports being written weekly instead of daily.

The size and immediacy of the 18-week challenge meant that a national solution was needed to focus on being practical and to overcome some key identified barriers: access to data for service improvement; the appropriate use of data to analyse the dynamics of variation and therefore decision making; and the capacity and capability to use data.

Using national data set returns that were already available focused on collection of stages of treatment rather than the whole patient pathway. An algorithm and set of assumptions, the No Delays Achiever website, provided instant access to waiting times for a whole patient journey for Trusts, not only by speciality but by drilling right down to consultant level data. It provided users with the evidence on where to focus their improvement approaches by giving them the information necessary to reduce the variation in their system. Shewhart (1931) and Deming (1994) showed that by reducing variation you improved your processes, and in this context this would reduce waiting times. The No Delays Achiever provided the NHS with the ability to see and therefore address the variation in patient waiting times.

Looking back on my presentations to NHS staff I found these words I had used:

Tackling variation is not only one of the most powerful strategies for purging waiting times. Evidence from across the globe demonstrates that it cuts waste, reduces patient mortality and enhances patient experience. We do not need separate strategies for hitting the 18 week target, controlling costs and improving patient safety. A focus on reducing variation hits all three bases. As NHS leaders, commissioners and providers, we need to be active variation busters.

I remember that it was responses to ‘variation busters’ that led me to actions to inform, rather than just give an inspirational talk and expect people to accept it at some level.

Generally NHS staff did not know the impact of tackling variation; they needed practical support to address the variation. Culturally, to clinicians the process of reducing variation was perceived as reducing their autonomy, so illustrations of the impact of reducing variation were critical to gain understanding and support. This led to a series of publications and case studies being produced and published on the Department of Health website’s 18-weeks page (now no longer available).

*Seven Ways to No Delays*⁶ (2008, v2), a key booklet by myself and Shouls, combined key learning from ‘Lean’, ‘theory of constraints’ and ‘clinical system improvement’:

1. Focus on the whole patient pathway
2. Plan ahead along all stages of a patient's pathway
3. Balance capacity and demand
4. Pool similar work together and share staff resources
5. Keep things moving—see and treat patients in order
6. Reduce things that do not add value to patients
7. Keep the flow—reduce unnecessary waits.

⁶ We used our shared expertise to identify the key areas; my co-author gathered the illustrative case studies.

The No Delays Achiever attempted to overcome the four barriers (Taylor and Shouls 2008):

- the availability of relevant outcome or process measures such as referral to treatment times
- analysis of available data to provide the right information for service improvement
- enabling the interpretation of the information to support decision making
- numeracy skills or knowledge of analytical techniques.

Addressing these barriers was critical to providing NHS staff with the information and the skills to reduce waiting times for patients and for them to appreciate that, in most cases, additional resources were not required.

Barriers: availability of relevant outcome or process measures

The No Delays Achiever addressed the lack of timely information without which service improvement would be hampered. A survey of NHS Trusts carried out by the NHSI (2006) identified the volume of analytical support required for the 18-weeks programme. This survey led me to estimate that to derive referral to treatment time data at specialty and sub-specialty level for one clinical team required at least 32 hours per week of analytical time. We concluded, 'In itself, this could act as a barrier to service improvement, as NHS Trusts' analytical teams had limited capacity and often provided the data without interpretation which wasn't sufficient to support improvement' (Taylor and Shouls 2008, p. 10).

It also revealed that a number of NHS Trusts were unable routinely to measure referral to treatment time even at specialty level, yet to transform services they would need it at procedural and clinician level. The No Delays Achiever was critical

in addressing this. This reflects the model for service improvement, which identifies that clinical teams need data to improve services (Langley et al. 1996).

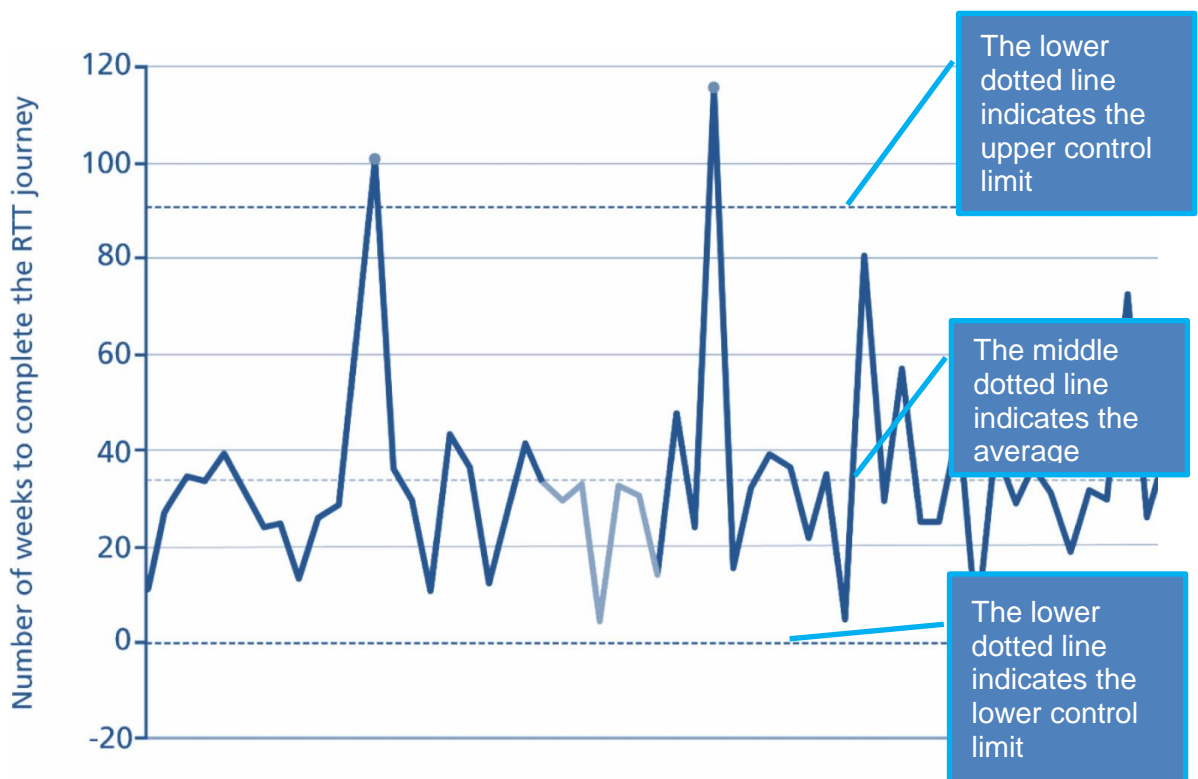
Barriers: analysis of available data to provide the right information for service improvement

In engaging with the NHS I frequently found myths about why waiting lists form. A common belief is that demand for services exceeds capacity to do the work and the result is waiting lists, regularly cited by NHS staff. However, there was mounting evidence in the NHS that this was not the case: 'In our experience, the variations in the health service's own capacity far outweigh any variations in demand placed on it by patients' (Silvester and Walley 2005b, p. 23). Further, analyses suggested that waiting lists in the NHS were quite stable, indicating that the reason waiting lists occurred was a temporary mismatch between demand and capacity as a result of variation (Silvester and Walley 2005a; Lee and Silvester, 2004; Silvester et al., 2004). Variation is clearly a problem to tackle for health services. In his model of improvement, Deming (1994) identified 'the knowledge of variation' as one of four parts to the system of 'profound knowledge' that leads to service improvement. The other three are: appreciation for a system, theory of knowledge, and psychology. As a system, real change requires all four areas to be addressed. Deming built on Shewhart's (1931) work that identified two key principles: Firstly variation is inevitable and, secondly, single observations form little or no basis for objective decision making. Taylor and Shouls (2008, p. 10) state that:

Traditional statistics describe variation often in terms of spread around a given distribution, with a focus on making a decision on whether or not two samples originate from the same population. In the case of clinical trials and observational studies, variation is deliberately reduced having, for example, matched sample and paired before/after tests. From an operational management perspective, a key strategy is to understand the dynamics of variation to ensure the appropriate employment of management strategies.

Knowing a monthly average is insufficient to deploy staffing resources to meet daily requirements, due to the variation in demand that occurs hourly, in other words to

match the demand of a service and its capability to meet it, for example through staffing levels. It was common to find staffing levels identical on all shifts, despite the demand for activity being variable through the day and week. Staffing levels should be adjusted to reflect the pattern of demand. There is also a simple deduction: the less variation in a process means it is more predictable and so easier to manage. A predictable process is more efficient than a non-predictable one. Services require less slack, fewer staff and therefore fewer resources to meet an upper level of demand that is lower in a predictable process. Taylor and Shouls (2008, p. 11) showed this as an example. In Figure 1 it is possible to see that, to ensure patients meet the 18-week referral to treatment time, it is necessary to reduce both the average (it was estimated that the average would be between seven and eight weeks) and the variation. In this instance, the level of variation indicates the process is not capable of meeting the target.



Source: Data originate from the No Delays Achiever: NHS Institute for Innovation and Improvement (2007)

Figure 1: Statistical process control chart: individual patient referral to treatment times for hand procedures

Each point represents a patient. The gap between the upper and lower control limits reveals the degree of variation.

Statistical process control (SPC) is a recognised tool to understand variation

Shewhart (1931) developed an approach to displaying and analysing run charts called Statistical Process Control charts. Statistical Process Control includes statistically based rules to interpret any unusual patterns in the plotted data. The power of the control chart is that it allows both retrospective analysis that supports the interpretation of the state of the process, and prospective analysis that allows dynamic monitoring of data to detect any shifts in the process (Taylor and Shouls 2008, p. 10). Shewhart (1931) identified two causes of variation: (1) common causes that result in minor fluctuations in the data, and (2) special causes—that is, causes can be assigned for the fluctuations observed and the data are unusual in their pattern compared with that normally displayed by chance causes. Both are useful to understand from an operational and clinical management perspective in the service sector (Wheeler 2003). Figure 1 illustrates a Statistical Process Control chart for individual referral to treatment times. The chart is made up of an average (mean) and two lines around the average—the upper and lower control limits (see **Appendix 11** for the method of calculation). There are different methods to calculate Statistical Process Control charts, which depend on the different type of data, for example samples of averages, individual data, proportionate. The potential of Statistical Process Control in healthcare settings has been described by others:

These case studies [six case studies on clinical systems including deaths following paediatric surgery in Bristol] illustrate an important role for Shewhart's approach to understanding and reducing variation. They demonstrate the simplicity and power of control charts at guiding their users towards appropriate action for improvement. (Mohammed et al. 2001, p. 466)

Barriers: enabling the interpretation of the information to support decision making

The No Delays Achiever used Statistical Process Control as it guided decision making in service improvement, as common causes and special causes of variation indicate the need for two different approaches to service improvement (Lloyd 2004).

Common cause variation requires the redesign of the processes. Resources may be wasted trying to understand why a particular point is high or low (special cause variation), when time would be better spent understanding the overall variation and making changes that address this variation in the system. Over-reacting to specific high or low values that are common cause can be described as 'tampering' (Taylor and Shouls 2008, p. 12). Understanding variation suggests different courses of action that require a good understanding with a greater knowledge of the processes and people's perspectives for effective change (Wheeler 1993).

Barriers: numeracy skills or knowledge of analytical techniques

As described by Taylor and Shouls (2008, p. 12), availability of data is necessary but alone is insufficient to enable services to improve. Conducting the right analyses is necessary but not sufficient. These analyses need interpretation and managers and clinicians need to use these to inform their decision making. This creates the potential for more barriers, such as around skills. There was emerging evidence of numeracy issues in society and the health service (NHS Education for Scotland 2006). Research commissioned by me through the NHSI showed that the skill levels in data analysis and interpretation for service improvement, part of 'clinical systems improvement', varies between Trusts (Walley et al. 2006). An interesting finding from this research was that capability was better in both high and low performing Trusts, with the majority of the Trusts with in-between performance having low levels of capability. The researchers concluded that the surprising capability in low performing Trusts was a result of intensive support programmes that had not yet had a chance to take effect on performance. It is possible, then, that some staff will avoid collecting and reviewing data, hampering service improvement as they make decisions based on feelings and impressions without confirming the concrete facts. Another barrier is the slow adoption of the use of Statistical Process Control charts

and run charts, despite their recognition as effective techniques to analyse healthcare process (Walley et al. 2006; Mohammed 2004). As these approaches are not taught in medical statistics, despite both having a rigorous basis in statistics, Statistical Process Control is viewed as inferior to other methods such as randomised control trials (Mohammed 2004). Taking this a step further, there is a suggestion that there are a number of staff who are skilled in analysis or interpretations of information but continue to use approaches less appropriate for service improvement. Any mechanism to support service improvement therefore needs to provide guidance and support confidence-building methods to interpret charts that are intuitive. Secondly, it needs to provide access to information about Statistical Process Control that demonstrates the strength of statistics behind the approach and its usefulness in a dynamic, operational environment.

Overcoming some of the barriers: The No Delays Achiever

As the Programme Director I initiated and led the development of the No Delays Achiever, a web-based service improvement tool (NHS Institute for Innovation and Improvement 2006). 'Given the size and the challenges for achieving an 18-week patient pathway, this tool had a specific focus on helping NHS Hospital Trusts to develop improvement strategies to achieve 18 weeks from referral to treatment' (Taylor and Shouls 2008, p. 13). By revealing the variation in their processes this provided a catalyst for discussion between managers and clinicians. It also assumed a lack of knowledge around the impact of addressing variation and knowing the right improvement tools to use, so this was done automatically for users. The web-based service improvement tool was found at www.institute.nhs.uk/NoDelaysAchiever.nhs.uk until this was turned off in 2009. The request to continue to fund it was turned down as the target had been achieved. This was an error, as waiting times continue to challenge the NHS and the resources to manage waiting times available through this website were unique.

See **Appendix 12** for a description and screen shots of the No Delays Achiever. Before it was terminated all the improvement tools were harvested and now reside on the NHSI website at www.institute.nhs.uk/qualitytools

Evidence of Public Impact

See **Appendix 13**

My Reflections and Learning

The No Delays Achiever addressed the issues that local improvement attempts were hampered by:

- lack of timely information
- capacity and capability to interpret data to guide improvement and reduce waiting times
- lack of easy access for NHS staff to data and information.

Measurement was necessary but not sufficient for hospitals to meet the 18-week referral to treatment times. Characteristics of successful hospitals besides the availability and understanding of data were identified in the King's Fund Report (Appleby et al. 2004). As healthcare systems are 'complex adaptive systems' (Sweeney and Griffiths 2002; Plsek and Greenhalgh 2001), a multifaceted approach is required to enable services to improve, which requires strong leadership at all levels (Reinertsen et al. 2005). 'This will ensure the culture of organisations support both major and minor service redesign' (Taylor and Shouls 2008, p. 16). This multifaceted approach is reflected in the theories relating to large-scale change (see public work on Leading Large-scale Change Programme).

The No Delays Achiever formed part of a solution to overcome some of the multifaceted barriers that can hamper an organisation's ability to transform services. As the 'No Delays Achiever' continued to evolve, it supported increasing numbers of registered users. Twelve months after it was launched, every Trust in the NHS was using the No Delays Achiever and through commissioned surveys I identified that users were demonstrating that it helped them to make a difference.

Access to the necessary data and information and advice about initial steps supported the redesign of services and, because achieving low waiting times reflected behaviours and demand in the whole health economy, the No Delays Achiever went on to provide data for commissioners of healthcare.

Most of the national and local efforts focused on supporting providers in achieving waiting time targets, but the whole system was not addressed. This was a flawed approach. However, in the light of system reform during 2007 and promoted by initiatives such as the NHS Acute Services Contract, commissioners were identifying how best to make the trade-off decisions between purchasing extra activity, improving health outcomes, reducing health inequalities and improving pathways. Establishing priorities for local health economies strikes at the heart of commissioning and PCTs, and Practice Based Commissioners (PBC) were developing and embedding the range of technical and behavioural capabilities necessary to make these trade-off decisions. This of course has to be re-learned under the major restructuring of NHS initiated by the Rt. Hon Andrew Lansley CBE MP who, as the Secretary of State for Health from May 2010 until September 2012, brought about the Health and Social Care Act 2012. The Act is one of the most controversial plans of the Coalition government, resulting in strong opposition from both the Royal College of Nursing and British Medical Association. Now we have clinical commissioning groups (CCGs) leading the commissioning of provider services with 80 per cent of the commissioning budget. My view is this constant turbulence of restructuring the NHS healthcare system is a hindrance to providing and commissioning high quality and efficient healthcare services. The relationships built over time between the commissioning PCTs and their providers have to now be established afresh with the new commissioning clinical groups.

The relationship between commissioners and providers is critical. Research would suggest that, for organisations and businesses to succeed, a mix of cooperative and competitive relationships with other organisations should be developed.

Brandenburger and Nalebuff (1997) call this mix 'co-opetition', whilst Di Minin (2004) refers to it as 'co-ompetition'. The theory and practice of 'co-opetition' was

developed to describe the way that organisations behave in business environments that call for them to compete with some buyers or suppliers whilst collaborating with others. Indeed, at times organisations may compete and cooperate with the same organisation at the same time (Dowling et al. 1996)

Reflecting on the 18-week waiting time target and the development of appropriate behaviours and organisational relationships with providers, clinicians, and patients, I would say there was a variety of individuals and organisations involved in the delivery of the 18-week pathways. A challenge for the commissioners was developing sophisticated relationships with different stakeholders that can work in a variety of contexts. These relationships needed to be based on trust, negotiation and market creation at one end of the spectrum, and performance management at the other. The ability, insight and control to use the most appropriate relationship at the most appropriate time to achieve the right outcomes required a sophisticated approach underpinned by a transparent evidence-based platform. Many PCTs were also developing different relationships with primary care practitioners and PBC to help manage utilisation of secondary care resources, redesign pathways and relate to secondary care clinicians. Relationships with patients were also a focal point for investment of commissioning capacity, as commissioners worked with communities to make trade-off decisions about where to invest resources, how best to support patients and communities to make choices about treatments, and how to ensure services are designed around patients' needs.

As the deadline for delivery of the 18-week pathways drew closer, it was clear that commissioners were using this opportunity to develop and apply new skills, capabilities and commissioning approaches. I reflect that in health economies where commissioners and providers had learnt to work in partnership and had good relationships, the challenge of the 18-week waiting time target was more readily addressed.

I saw the most sustainable waiting times reductions when NHS staff:

- used data to focus their efforts
- used quality and improvement tools to redesign service provision, and
- where there were good relationship between providers and commissioners of healthcare.

In 2010 I worked with Barry Oshrey. His definition of partnership was, 'A relationship in which we are jointly committed to the success of whatever endeavour, process or project we are engaged in' (Oshrey 2007, p. 117). If commissioners and providers of healthcare were able to establish this partnership approach and work together to meet the health needs of the local population alongside the primary care, perhaps they would be more willing to make compromises on both sides. However, I feel the development of Foundation Trusts with significant managerial and fiscal autonomy means there is less willingness to take a partnership approach to local healthcare. These now established organisations appear strong compared to the embryonic CCGs, so it will be some time before relationships will be robust enough to become true partners.

The impact of good relationships is underestimated. The drive for good value is promulgated by driving competition between providers to drive down cost. However, healthcare provision is part of a complex system of factors driving the demand for healthcare. The Coalition government has attempted to design different system levers for improvement through different relationships:

- GPs (the gatekeepers) replace managers as the commissioners so their referral patterns have a fiscal impact
- The development of cross-organisational Health and Wellbeing Boards⁷ has the potential to address some of the health determinants.

⁷ The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The Health and Social Care Bill mandates a minimum membership of: one local elected representative; a representative of local Healthwatch

Commissioners are part of these boards, but providers of acute care are not represented, so learning from them is not considered.

The Kaiser Permanente⁸ model in California is making progress on reducing disease, it can be seen, as they have a fiscal driver. Acting as both the insurer and the provider, if services reduce demand they increase their profit. Here in the NHS, commissioners and providers sit on opposite sides of the fence so, unless there are robust partnerships, the tussle will be between generating income (providers) versus controlling expenditure. This link to good relationships harks back to my IPAS experience as a 'broker' of relationships, critical to improving the understanding of all parties when tackling large-scale change for improvement.

I chose to respond to the request to support the NHS in tackling the 18-week challenge in a pragmatic way, providing support succinctly and quickly. Initially I took a 'small-scale change' improvement science approach, providing service providers with the tools to redesign their services at a process level. However, this national large-scale change needed to be tackled from a broad range of perspectives and with a strategic lens. There were drivers in the system to keep long waiting lists. For example, it was purported that medical consultants profited from long waiting lists by offering private alternatives and, if increased efficiency resulted in increased throughput, the commissioner of the services would be challenged to meet that increased cost.

organisation; a representative of each local clinical commissioning group; the local authority director for adult social services; the local authority director for children's services; the director of public health for the local authority.

⁸ Kaiser Permanente is an integrated managed care consortium founded in 1945 by industrialist Henry J. Kaiser and physician Sidney Garfield. Kaiser Permanente is made up of three distinct groups of entities: the Kaiser Foundation Health Plan and its regional operating subsidiaries; Kaiser Foundation Hospitals; and the autonomous regional Permanente Medical Groups.

The Department of Health tackled the waiting time target with many initiatives focused usually on areas with the longest waits, for instance orthopaedics. In other words it focused on processes in the system, that is, much ‘small-scale change’ that is a necessary component of large-scale change. However, I would suggest that a more effective approach to supporting the NHS delivery of this national service improvement would be through the lens of leading large-scale change. A large-scale change model of approach would have created a strong vision, encouraging wide-spread leadership of the change, recognising the value of influence, the reality of emergence and the multifaceted approach needed in large-scale change (see public work on Leading Large-scale Change Programme).

Reflecting on the learning gained by colleagues when NHSI ran an ‘Academy for Large-scale Change’ (October 2008–March 2010), the programme identified a range of leadership traits (**Appendix 14**) necessary to be able to lead large-scale, as opposed to small-scale change (identified through semi-structured interviews with the participants).

These behaviours reflect the different approach to large-scale change where you have to work across different organisational boundaries using influencing skills, not authority, to deliver the change. Many of these ‘large-scale change’ leadership traits are typically not rewarded in the NHS, which has had years of performance management by governments through the delivery of ‘targets’ (see examples of NHS targets in **Appendix 15**).

Delivering large-scale change in complex systems such as the NHS requires integrated changes in structures, processes and patterns (of behaviour and outcome) as described by Plsek and Greenhalgh (2001). Large-scale change regrettably is often *not* what we attempt to do in change efforts; frequently we take a fragmented approach:

- structural changes, without really changing processes or behaviour patterns
- changes in care processes and pathways that are then not supported by changes in structures and behaviours, and
- attempts to alter behaviours without really addressing structures and patterns/processes, for example, through targets or training alone.

Therefore, the traditional approach of using hierarchy to control is much less useful for the complexities of large systems like the NHS. In this environment there are competing values and objectives, so leaders may defend their own interests rather than support the vision of (in this case) reduced waiting times for patients. It is easier to jump to simpler solutions that may actually compound the existing problems.

Some health economies in the NHS had local leaders who tackled the waiting time target, together working in a more inclusive way. They tended to focus on solutions for the whole system rather than just themselves, rather like Oshreys' (2007) definition of partnership. I also observed that these communities tended to be more inclusive, engaging with patient and community representatives so that all the stakeholders of the system had an appreciation of tensions and impacts of certain behaviours and they contributed ideas to improve care thus increasing innovation. This is reflected in the subsequently published *The Human Factor* (Bunt and Harris 2009), which identified that engaging the public can save money and lives. This is much more akin to bringing about large-scale change through social movements.

Ganz (2010) describes a model of organising leadership for change at scale:

To practice leadership is like the interconnections of a snowflake: Where leadership is exercised not through formal authority or personal charisma but by developing other leaders who, in turn, develop other leaders, all the way down. Although 'you' may be the dot in the middle, your success depends on developing the leadership of others.

It is not about absorbing all the responsibility yourself. It is about empowering others; delegating responsibilities (rather than tasks) and challenging them to carry out that responsibility, but also supporting them and providing guidance in their work and letting all members of the team share the work. Although you may be the dot in the middle of a team or organisation, your success and leadership depend on developing the leadership of others and building the capacity of your campaign or call to action.

The empowered leadership model is given high emphasis in calls to action or community organising, because every person in the team shares accountability on an equal basis. Members of a team hold each other to account in a way that they have not traditionally done as they are volunteers and a traditional organisational hierarchy does not apply.

However, the NHS is not an organisation of volunteers like those with whom Ganz was working. As Malby and McKenzie (2012) describe, it is well understood that for the shared leadership model of system leadership to be effective, all those involved need to develop new ways of working and demonstrate a different set of leadership behaviours: ‘for example, system leadership is not possible without collective responsibility.’ So we return to the challenge of aligning systems process and patterns.

My own leadership style is about empowering others to address challenges and bring about improvement. It reflects the approach I took with IPAS: set stretching goals but support others in achieving those goals; ‘to be the water and fertiliser in a garden’. It is reflected in the ‘celebration events’ I run at the close of programmes.

A final reflection on framing of the 18-week ‘target’ is that, in an era of a succession of targets (for examples see **Appendix 15**), this 18-week target became something that increased the tension between clinicians and managers. No-one stopped to think it might be a good idea for waiting times to be reduced. There were anecdotes of clinicians complaining it would impact negatively on their lucrative

private practice and that all targets were driven by managers thus inherently bad, as they might erroneously influence a clinical decision.

Yet waiting time targets were not inherently bad. The reasons are that often the NHS has dealt with healthcare waiting times by prioritising, ring fencing or carving out the time of an expert, the time of specialised equipment or by keeping resources or facilities only for one particular group of patients. By carving out in this way, the process of care for one group of patients is prioritised over another, irrespective of their needs. For example, a GP practice might give priority to all pregnant women with diabetes and offer them urgent appointments, while another diabetic patient will have to wait. Prioritising in this way interrupts the flow for other patients who inevitably end up waiting longer. Accurate measuring of the backlog or waiting time for other groups of patients has shown that carving out capacity significantly increases waiting times overall and creates a difficult system to manage effectively. A published illustration of this appeared in 2005. This showed how carve out did not detect early cancers—it was better to reduce waiting for everyone. They concluded that an increase in the detection of early stage cancer was primarily due to a reduction in routine waiting times rather than the two-week target (urgent cancer referrals). They achieved this by increasing capacity through role redesign (nurse endoscopy) (Spahos et al. 2005), so demonstrating that reducing waiting times to everyone was beneficial.

I consider the government and the Department of Health framed the reduction of waiting times for the clinicians badly. There was no articulated description that would win over the clinicians and there was no a sense of shared purpose, winning everyone over for the benefit of the public, future and existing patients. I attempted to address this by naming my team 'No Delays' not 'The 18-week Target Team', as many others were termed in NHS organisations across the country. I role modelled talking about making things better for patients and staff.

However, the Department of Health is not unique in getting this wrong, according to Keller and Aiken (2008, p. 3) 'What the leader cares about (and on which he/she

typically bases at least 80% of his or her message to others) does not tap into roughly 80% of the workforce's primary motivators for putting extra energy into the change programme'.

Literature on social movements describes in detail the importance and impact of framing. Snow and Benford (1992) talked about the mobilising potency of 'Master frames' and how, if the aim is not framed appropriately, it can alienate and disengage people. Kotter and Cohen (2002, p. 1) stated 'people change what they do less because they are given analysis that shifts their thinking than because they are shown a truth that influences their feelings'. They introduce a new dynamic—'see-feel-change'—that sparks and fuels action by showing people potent reasons for change that charge their emotions. Kelman (2005, p. 6) states, 'Often change need not be cajoled or coerced. Instead it can be unleashed.' Denning (2007) describes how organisations focus more on facts and figures to influence change. The persuasive power of stories has been increasingly rediscovered. Storytelling is the intersection of leadership and influence. In a story, the teller vividly brings a situation to life in a familiar context, using it to insert subtle influencing techniques; 'an appropriately told story has the power to... communicate a strange new idea easily and naturally and quickly gets people into enthusiastic positive action' Denning (2007, p. 38).

These texts all talk about framing and using stories to tap into individual values, eliciting emotions in order to drive and gain action towards a cause. I often recount tales, but critically I do this when supporting others to improve and change as a way to illustrate the shared importance of the work, the impact on me, themselves and the community they are supporting, thus demonstrating how the work is important and worth the pain of the change.

I consider that commitment to this government target—18 weeks' maximum wait from GP referral to treatment—might have been very different if the framing had been given considerable thought and attention, affecting the response by clinicians and managers of the NHS. I believe this applies to many of the targets imposed on

healthcare. If they could be framed in a way that demonstrates caring for patients, it would engage NHS staff in a more viable way by identifying with what is important to them.

My Learning in Summary

The No Delays Achiever addressed the issues by which the local improvement attempts were hampered: the lack of timely information; the capacity and capability to interpret data to guide improvement and reduce waiting times; and lack of easy access for NHS staff to data and information.

A multifaceted approach is required to bring about change in complex adaptive systems, and to bring about sustainable change a whole-system approach should have been taken by the Department of Health. Where there was genuine partnership working between commissioners and providers the target was more readily addressed and sustained. Demonstrating shared leadership is critical to delivering complex change in a system.

If the Department of Health had framed the reduction of waiting times in a way that focused on the benefits to patients and NHS staff there may have been better engagement. More attention was needed on how problems and solutions are 'framed.' I am thinking about myself, too, and how frame I frame good leadership and good management for myself and for others.

iLinks—Supporting NHS Trusts to Improve (2008–2009)

My Role

National Programme Director, designer, an author and editor.

I was asked to lead the programme iLinks, which was established in spring 2008, as my integration approach to data and service improvement tools in the No Delays Programme of work was thought by my CEO to be a useful approach for this programme of work.

Context

My employment, the NHSI existing strategy (2007), had led to the development of a large number of products and tools for service improvement. It had, however, also become apparent that NHS organisations found it difficult to identify easily which tool was most appropriate for their own given challenge.

The objective set by the Chief Executive of the NHSI was that by ‘smarter packaging’ (bundling/integrating/linking) of our products, we could make them more potent for the NHS.

‘Over the first two years of operation the NHSI had developed effective interventions that were being used by many NHS organisations to improve patient care.’ It was proposed in 2008 that ‘we consolidate the learning from these developments into a range of ‘packages of linked products and services’ that drew together tools and approaches from across the spectrum of work in which the NHSI engaged. The hypothesis was the integration of products would reveal that the sum is greater than the parts.

An important starting point for this work had been the development of the No Delays Achiever; the web-based tool which integrated data and descriptions of over 100 service improvement tools and approaches. Therefore it was assumed that integrating NHSI products could be done in a similar way (without the data element). The NHSI Annual Report and Account for the period 1 April 2007—31 March 2008 stipulated; ‘iLinks, *a new programme creating customised packages of NHS Institute products to meet the needs of different types of NHS organisation*’. (NHSI 2007–08, p. 15)

iLinks—The assumption: That an integrated approach could help overcome the two key barriers to service improvement: capability and capacity

Research indicated that two of the key barriers to service improvement in the NHS are capability and capacity (Walley, Rayment and Cooke 2006). Therefore, by helping the NHS to understand where they needed to focus their efforts (given their own local priorities) and providing the correct tools suitable to tackle those particular issues, the impact of those two barriers would be reduced. This had been one of the key successes of the No Delays Achiever.

My Proposal

I proposed a strong emphasis on co-production with the NHS to ensure the final outcomes met the NHS needs. It was important not to pre-empt solutions until engagement with NHS staff and research on their views was complete. I would carry out research to fully understand the NHS staff perspectives and views on:

- how they would like to see information presented
- the key challenges for ‘bundles of products’ to be aligned against.

I anticipated that success was likely to include the following:

- An NHSI-wide strategy for aligning tools, models and approaches into ‘packages or solution sets’ that meet the needs of specific NHS-customer groups. They might include:

- packaging of specific knowledge
- strategies for building local skills around these tools and approaches.

(See **Appendix 16** for the iLinks Business Plan.)

It was anticipated this would help the NHS by enabling universal access to customised service improvement approaches. I aimed to create a foundational body of knowledge using NHSI products, improvement tools and methods, and programme management approaches. That would support the NHS staff by providing readily accessible information on a range of techniques and how they could be applied to different challenges, framed in ways that meet the needs of specific NHS staff groups.

I advertised for pilot sites to work with on this in co-production. An application form completed by a Trust can be seen in **Appendix 17**, and competition was fierce. Trusts recognised the advantage of the additional resources and ‘skilling up’ of their staff and an opportunity to ‘be ahead of the curve’. We looked for a diversity of Trusts: large, small, specialist and general. Applications were usually eliminated though inability to show commitment to the work at executive level, as my experience had shown that this was essential in order to see through a programme of work. Trusts were required to identify key problems that they wanted support with and we would test out how we could respond using NHSI products and evaluate the impact.

There are some arguments against co-production. It is purported that Henry Ford famously said ‘if I had asked people what they wanted they would have said faster horses’. However, I think engaging in creativity and innovation approaches with your customers gives insight into their world and improves your understanding of their needs. It means one can tailor ‘products’ to their needs and improve uptake and engagement.

The first pilot Trust listed a range of challenges for us to address: Theatre Efficiency Capacity Planning, Cancelled Operations and Workforce Productivity. It transpired this was difficult as there were limited NHSI products designed to support these specific issues. However, experience on the 18-week target meant I could spot the signs of a Trust describing symptoms rather than the cause. I suspected that achieving the 18-week target for elective procedures and prioritising them was affecting the Trust's ability to manage non-electives, thus increasing cancelled operations. It looked like a mismatch between demand and capacity, probably brought about by attempting to address the 18-week wait by 'carve out', in other words prioritising by ring fencing resources for a group of patients. This interrupts the flow of other patients, who inevitably end up waiting longer.

I decided to do a diagnostic before the initial visit using publically available data. It revealed:

- highest rating achievable within Monitor's risk ratings⁹
- excellent scores within Health Care Commission 2006/07¹⁰ annual health check
- achieving 18 weeks
- achieving A & E four-hour targets
- financial balance
- Health Protection Agency;¹¹ October–December 2007 two to three cases of MRSA, thus low rate
- aiming to constantly improve—the Trust had won a recent award
- above-average score on staff satisfaction.

⁹ <http://www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/nhs-foundation-trust-performance/actual-performance/risk-ratings>

¹⁰ <http://ratings2007.healthcarecommission.org.uk/>

¹¹ <http://www.hpa.org.uk/HPAwebHome/>

(See **Appendix 18** for details on the three options tested and the output for this co-production Trust.)

This Trust chose the option where we conducted a diagnostic to help identify and define their key areas for improvement and then match NHSI products that could support those areas. It seemed it was all going as planned.

I developed a diagnostic which tested successfully with all the pilot sites. The aim was to provide a set of tools that can be used within test sites to explore the potential areas for development in the area of service improvement. The tools were aligned around the framework set out by Bate, Mendel and Robert (2007) in their work 'Organising for Quality: The improvement journeys of leading hospitals in Europe and the United States'. They carried out case studies of organisations where successful quality improvement programmes have been implemented, and found that there are:

Six common challenges that are problems to which any organization will need to find solutions that will work for them in their particular context and that if they do not do so will ultimately lead to disappointment and failure in the quality arena. (Bate, Mendal and Robert 2007, p. 167)

That organisations must:

- a. be aware that one needs to take up each and every one of these six organizational challenges (as did our case study sites), given that they are imperatives or 'must do's', not luxuries or add-ons to a QI effort
- b. find answers to each that fit locally and are contextually appropriate (find the right key for the right lock)
- c. build them into your on-going organisational and service improvement processes. (Bate, Mendal and Robert 2007, p. 168)

The six characteristics are:

- **Structural** process (planning and coordination)
- **Political** process (negotiating change and managing conflict)
- **Cultural** process (giving 'quality' a shared, collective meaning)
- **Educational** process (learning and accumulating knowledge)
- **Emotional** process (motivating)
- **Physical** and **technological** process (design of technical and other systems).

However, the existing NHSI products were insufficient to support the work. The products had not been developed in response to the day-to-day challenges of the NHS or the need to 'skill up' NHS staff in improvement science. NHSI products were largely created in response to demands of the Department of Health which tended not to focus on day-to-day challenges.

Critical Points

In reporting back to the NHSI management meeting I used the following metaphor: 'It felt like you had asked me to design and deliver a large elaborate dinner party, but then I had to go to the local corner shop and they only sold limited tinned items...'. The reality was the tools that worked for the co-production sites were the generic service improvement tools and techniques that could be applied in all situations where you needed to improve processes.

This outcome was repeated again and again as we worked with Trusts. In some ways it was not surprising the No Delays Achiever (NDA) met the needs of the NHS in terms of access to valid service improvement tools, approaches and techniques. It had been aimed at providing NHS staff with the knowledge base to address their own problems. Surveys conducted during the design phase of the NDA revealed that at that time in 2006 there was no single resource for service improvement tools, approaches and techniques. The service improvement resources in the NDA formed a strong basis from which to build a series of packages of product offerings to help improve healthcare provision. What was surprising was the NHSI products were not aligned to the daily NHS challenges. Instead, they were aligned to the

priorities as dictated by the Department of Health, which focused on policy that was not always the Trusts' primary focus.

Again, the co-production Trusts were unanimous in stating that the signposting of a process offered some value, but that they would remain reliant on access to people with these skills, and that they wanted to be able to diagnose and apply the relevant tools themselves. So, in order to respond to their needs it was not a 'bundle' of NHSI products that emerged but an education programme to 'skill up' NHS staff to solve their own challenges.

The two key solutions that emerged out of the work with our co-production sites were:

- an educational programme called Organising for Quality and Value (O4QV)¹²
- an interactive PDF, 'A Step By Step Guide to Tackling Your Challenges'¹³ which linked the top NHS 19 challenges to the relevant service improvement tools, approaches and techniques.

This response to the needs of the co-production sites was resoundingly positive.

¹²http://www.institute.nhs.uk/quality_and_value/organising_for_quality_and_value/_organising_for_quality_and_value_homepage.html

¹³ 'Tackling your challenges' publication: http://www.institute.nhs.uk/index.php?option=com_joomla&Itemid=194&main_page=document_product_info&cPath=89&products_id=682&Joomlaartid=t3aban6podd1m7d5523ntdjva1

Organising for Quality and Value (O4QV): Delivering Improvement programme

O4QV supported NHS organisations that wanted to develop the service improvement skills of their clinical and operational staff. It helped organisations to equip their teams with the skills and confidence to roll out proven service improvement techniques and projects where quality, value, productivity and safety of patient care can be improved. The core service improvement knowledge gained during the programme, along with the skills and approaches learnt, would help make service improvement projects more successful. The pilot sites moved from a 30 per cent success rate in change projects (as judged by their own key performance indicators) to a 60 per cent success rate. Delivered over a three to four month period, the five-day modular training programme helped delegates to work through the following key service improvement development modules:

- leading improvement
- project management
- sustainability
- engaging, involving and understanding others' perspectives
- process mapping
- the role of creativity in improvement
- measurement for improvement
- demand and capacity management.

I initiated this programme in 2008 and was Programme Director until February 2010.

(Appendix 19 shows the programme overview.)

Using my knowledge and experience of service improvement science I designed the curriculum of this developmental programme and did the detailed work on

developing some of the modules, associated workbook and slide sets with speaker notes. Other modules were developed by my team.

I received very positive feedback in response to the O4QV programme—see **Appendix 20**.

O4QV programme was one of the most successful programmes of the NHSI, despite being offered at a time when funding for the NHSI was changing so we had to charge NHS Trusts for the delivery of the programme. The O4QV programme had a taught component delivered in conjunction with action learning sets and coaching the delivery of an improvement project (action learning) so designed to use all the key components essential for robust adult learning as described previously.

A Step-By-Step Guide to Tackling Your Challenges

This guide mapped some of the key challenges that the surveyed NHS staff told me faced the health service, against a range of quality and improvement tools and products developed by the NHSI to support the NHS in improving the quality, productivity and efficiency of services.

In compiling the evidence for the *A Step-By-Step Guide to Tackling Your Challenges* (see below for the detail) I gained the views of 700 NHS staff through surveys asking them what were their key challenges and how they wanted support on addressing them. This identified that they wanted training on and access (internet-based) to service improvement tools, approaches and techniques. They wanted internet-based access to good practice. The service improvement tools, approaches and techniques on the No Delays Achiever were a key source, but were only approached if addressing the 18-week referral to treatment time target. Loading up all the tools in the NHSI website was a quick win. Publishing a book with the same content broadened access for NHS staff with limited internet access.

Evidence for the Challenges Addressed in this Publication

In compiling the list of challenges to be included within this document, I used three sources of primary evidence:

- research carried out by a market research company (TNS, 'Customer Needs Research') 450 responses with a response rate of 41%
- structured interviews carried out at NHS Confederation conference, June 2008 with a range of 150 senior leaders in the NHS, conducted by me and a colleague
- feedback from a hundred NHS staff during prototyping sessions in July–August 2008 that I led, supported by my team.

These three sources gave a wide range of outputs, varying from strategic to operational, detailed to broad issues. I took all of these outputs, grouped and interpreted them to some extent and built packages around those where tackling the challenge required a process of quality improvement using a package of tools.

I also used secondary evidence, which had been used to inform other NHSI tools and products. For example, we had a variety of responses that either mentioned finances and productivity or factors that cause waste (DNA rates, cancelled operations, etc.). Therefore we used the themes identified by the NHS Productivity metrics as having both a wide spread across Trusts, and a potential for improving productivity (this included follow-up rates and surgical thresholds).

There was one key challenge that was omitted; that of 'World Class Commissioning (WCC)',¹⁴ because the NHSI already has a comprehensive programme supporting

¹⁴ Launched in December 2007, World Class Commissioning was a national programme, developed by the Department of Health in partnership with the NHS. WCC was built on the international evidence base of commissioning best practice, and is aimed at developing world class commissioners of NHS-funded services.

commissioning across the cycle. I did, however, expect that the knowledge and skills involved in WCC would be utilised in any of these quality improvement projects.

(For a summary of the guide content, see **Appendix 21**.)

Evidence of Public Impact

See **Appendix 22**

My Reflections and Learning

I was working with Trusts which, on the whole, were attempting to deliver small-scale change focused on improving processes and not working across organisation boundaries. So the application of the quality and service improvement tools, techniques and approaches as identified in the No Delays Achiever and in The Handbook of Quality and Service Improvement Tools¹⁵ was wholly relevant.

Delivering a value proposition or products: As the programme developed, it had become clear that the approach was more effective if the proposition was based upon delivering ‘value’ rather than ‘products’. This is because a value proposition is of higher value to clients and can link to creative risk sharing approaches. However, it required greater insight on the part of the NHSI staff involved and required further diligence on the organisational capacity of the ‘purchaser’ organisation.

So a key learning was Trusts did not want ‘products’ *per se*. They valued the ones that gave them access to their own data interpreted (No Delays Achiever and the NHSI Indicator Explorer tool). The evidence base for the NDA had revealed that

¹⁵ http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&cPath=89&products_id=691&Joomcartid=t3aban6poddIm7d5523ntdjva1

Trusts did not have sufficient analytical support. Trusts wanted the ability to solve their own problems and sought sustainable solutions to this, such as the 'skilling up' of their own staff. The O4QV programme was designed to give them the skills to solve their problems.

Critically, the products that the NHSI were producing at the time were in response to the needs of their sponsor, the Department of Health, and these did not appear aligned to the day-to-day challenges of the NHS (with the exception of the data tools described). I have already described the importance of framing and I think the same applies to the 'products' that the NHSI was producing at the time. They failed to link overtly with the day-to-day challenges of providing healthcare. Subsequently the NHSI did start to frame its products more appropriately, for example a range of products, the 'Productive' series, using the 'Lean' approach resulted in more efficient use of resources, for instance the 'Productive Ward' started to use terms such as 'releasing time to care'. This was so effective that the Chief Nurse of the NHS at the time mandated Trusts to use 'Productive Ward'.

I reflect on the stance I had taken in IPAS. 'Supporting the system to help itself' is what the hospitals were asking for. The popular ones were generic improvement products and publications produced by the NHSI for Innovation and Improvement that enabled Trusts to help themselves. Educational and development programmes to skill people up in improvement and successfully deliver change are what they wanted.

Critically the learning had to be real and relevant, that is, aligned to the principles of adult learning (Knowles 1973/1990). The O4QV programme participants had to deliver a project to consolidate their learning. This transpired to be a successful approach but ONLY if the projects were aligned to the Trusts' organisational strategic perspectives; so we put a link person in, to support participants in gaining sponsorship and alignment of their project.

This learning has shaped subsequent programmes I have designed and delivered. For example I ran the national NHS Vanguard¹⁶ programme for emerging leaders. The leaders were introduced to some key theories, had to deliver a project and critically, had a local sponsor who attended all the theory sessions with them. It means their work is aligned to their organisation, contextually relevant and with a local champion who can speak the same language.

Research Capability

My knowledge on conducting research had been gained through my undergraduate and postgraduate degree dissertations, which focused on the theory around conducting research. The joy of doing my roles at a national level was the opportunity to commission and conduct research to gain learning and knowledge to inform our work—applied research.

For smaller pieces of work I would design and conduct the research myself, largely surveys, focus groups and interviews. For larger pieces of work I would commission an organisation to conduct the research. Even the act of commissioning research helped to inform and consolidate my learning of research. If the research was for the purpose of evaluation of a programme, usually I would get a third party involved to reduce researcher bias. Depending upon the nature of the research, techniques varied from conducting focus groups with rich qualitative data to large-scale surveys, qualitative and quantitative. I commissioned research in order to inform my thinking around new areas of work. For example, I recently commissioned an innovation cycle approach to understanding building capability for improvement and innovation at scale in the NHS (see **Appendix 23** for a description of this approach).

The research I regularly conduct would be described as exploratory or descriptive research. When evaluating the impact of the ‘No Delays Achiever’ I attempted some analytical research in trying to identify any relationship between use of the ‘No Delays Achiever’ and a Trust’s ability to achieve the 18-week target. The factors

impacting on waiting times are so diverse—the variables—that this proved to be very difficult and we could only make such a deduction with our test sites.

Being practised in using flexible approaches to problem solving means I am experienced at developing prototypes to gain insight into what could be viable solutions.

Evaluating the impact of my programmes is integral to my work. This means I am able to use the insight to improve future programmes of work. For example, I directed a developmental programme for emerging leaders, NHS Vanguard¹⁶ (2011–13). The impact of this programme was assessed by:

- a baseline audit to ascertain knowledge levels
- after each web-seminar a questionnaire to explore the effectiveness of the learning gained
- a final evaluation in the assessment process of the students to see how they were able to integrate and utilise their learning in successfully delivering service improvement through their project.

The learning gained from this evaluation shaped the second delivery of this programme.

As Director, my role had moved to reviewing the design and questionnaires my team devised. They were piloted before being administered. The team also had access to ‘research and development’ experts in this field who gave advice on more complex areas of investigation.

¹⁶ http://www.institute.nhs.uk/qipp/calls_to_action/the_vanguard_programme.html

My Learning in Summary

Day-to-day challenges of a Trust are not always aligned to current policy agendas, so national support may have a different focus. Trusts like to be enabled to address their own challenges. It was clear that the support was more effective if the proposition was based upon delivering 'value' rather than 'products'. This was because a value proposition is of higher value to clients and can link to creative risk sharing approaches. Developmental programmes to support this need to be aligned to the Trusts' strategic objectives and participants need to work on aligned improvement projects. The value of research is to substantiate strategy and action.

Leading Large-scale Change Programme (2011–2013)

A developmental support programme providing practical help to deliver transformational change within participant's healthcare system¹⁷

My Role

Director of Learning and Development: Directed and co-designed the programme with a team member, I was part of the teaching faculty and the 'expert' in 'Public Narrative Skills'.

Context

To quote a colleague:

We are at an extraordinary inflection point in the history of the NHS, a time of uncertainty and transition but also a time of great possibility. An extraordinary leadership response is required to meet the challenges before us. We have the potential to rewrite the rules forever on how to galvanise an entire system for change. (Helen Bevan 2011)

The timing seemed right to design and deliver a new programme to support organisations across the healthcare and social care systems to deliver large-scale change. The NHSI had run an 'Academy for Large-scale Change' in 2008 and used a broad range of theories to experiment with. It produced a model for large-scale change (Figure 2) that was used for this new 2012 programme.

¹⁷ http://www.institute.nhs.uk/leading_large_scale_change/information/leading_large_scale_change_homepage.html
http://www.institute.nhs.uk/leading_large_scale_change/general/leading_large_scale_change_homepage.html

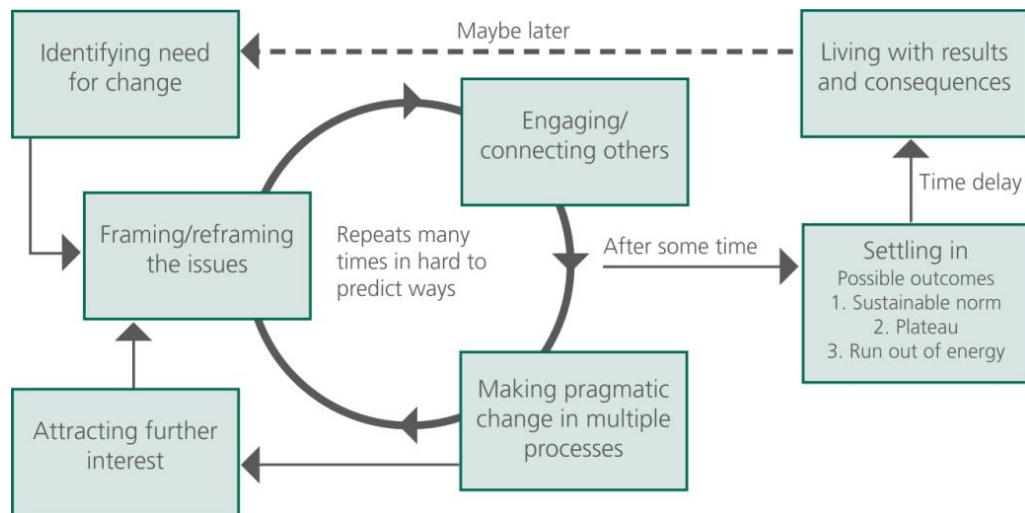


Figure 2: Model for large-scale change

The 2008 Academy for Large-scale Change gave its working definition as:

Large-scale change is the emergent process of moving a large collection of individuals, groups, and organisation toward a vision of a fundamentally new future state, by means of high-leverage key themes, distributed leadership, massive and active engagement of stakeholders, and mutually-reinforcing changes in multiple systems and processes, leading to such deep changes in attitudes, beliefs and behaviour that sustainability becomes largely inherent.

The 2008 Academy was a programme rich in time and resources but was aimed at individuals. In reality large-scale change is delivered by teams of people working collaboratively in partnership and they are ‘time poor’, so this new programme needed to reflect this.

I reviewed the evaluations of the Academy, interviewed 20 per cent of the Academy participants and explored the literature on delivering large-scale change (see **Appendix 27** for a sample of LSC literature reviewed). This revealed the most valuable aspects of the Academy, what had worked well and what had not added value. For example, face-to-face protected time in the workshops to work on their

large-scale change was highly valued. The literature review shaped the curriculum of the 'Leading Large-scale Change Programme'.

I had also spent the previous two years working with Professor Marshal Ganz from Harvard University, understanding how social movements bring about large-scale change. This was achieved through undertaking the Harvard Kennedy School Executive Education programme in Leadership, Organizing and Action: Leading Change designed and delivered by Professor Ganz, followed by two years being coached in 'community organising'. This learning added a module on 'public narrative', a motivational storytelling technique to gain commitment to the change one wants to bring about.

The outcome was a tight curriculum (**Appendix 24**) focused on the reality of delivering large-scale change through teams working across organisational boundaries. Coaching was identified by the participants of the Academy as invaluable for the teams delivering the change. Public narrative, a storytelling technique to engage others in the large-scale change (from social movements), culture for innovation and skilling up in creativity tools and techniques were added to the curriculum to support second-order change and problem solving.

The Leading Large-scale Change Programme was specifically designed to address the complex challenges faced by today's NHS senior leaders. It focused on their need to deliver massive changes across healthcare systems. It was based around supporting teams working on transformational strategies that needed to deepen their understanding of how to deliver change at scale and pace. It provided a combination of capability development, theoretical insight and reflective application.

The six-month programme was provided through a mixture of workshops, virtual learning and team coaching to support NHS leaders in making change a reality. The unique combination of access to the latest thinking on delivering large-scale

change, practical advice from highly experienced coaches and opportunities for peer discussion and co-learning was structured to provide protected team time, (identified through interviews, senior busy people really appreciated this aspect), and to apply new change techniques whilst minimising off-site requirements.

The programme was designed¹⁸ by me, alongside a colleague and with some input from a member of the teaching faculty from the 2008 Academy. It was based on five delivery modules (Table 2) and structured to build team and personal capabilities in large-scale change whilst simultaneously applying the learning to transformational projects. Unique to this programme, each team received coaching sessions from an expert in large-scale change to help them translate the learning into their local context. This had been identified by the Academy as a positive element.

What do we mean by LSC and a model for delivering it	<ul style="list-style-type: none"> • Understanding the meaning of LSC and models of best practice • Getting the early stages right and creating a culture of innovation
You as a leader of LSC	<ul style="list-style-type: none"> • Building your own personal leadership power, leading through others and the role of the public narrative • Key LSC leadership skills (old and new) and navigating polarities
Creating and sustaining committed others	<ul style="list-style-type: none"> • Building commitment, the learning from social movements, shifting mindset and creative engagement • Working with individuals – enthusiasts to sceptics
Methods to ensure delivery	<ul style="list-style-type: none"> • Programme leadership, aligning processes and moving to business as usual • Realising benefits and maintaining momentum
Learning from practice	<ul style="list-style-type: none"> • Learning from peers and the ‘wisdom in the room’ • Exploring the complexities, levers and drivers of healthcare transformation – sharing tactics that work

Table 2: Leading large-scale change delivery modules

This programme was designed for teams of six people who were jointly leading the delivery of a significant transformational change programme. Participants were

¹⁸ I chaired this design team and used past experience to design the structure of delivery. The curriculum was a result of the three of us appraising the literature and debating the order and priority of the key topic areas, based upon our experience of delivering large-scale change and coaching NHS staff delivering large-scale change.

senior leaders (e.g. director level) who already had experience of delivering major change but who wanted to learn new approaches to working across organisational or system boundaries to implement complex change programmes. Examples of the types of focus areas for teams included:

- redesigning urgent care services across primary and secondary care to reduce emergency admissions
- a multi-agency effort to reduce alcohol-related harm within a major city
- developing a CCG approach to system-wide working to improve services for the frail elderly.

I suggested that teams should include members from across the relevant health and social care system with representation from acute services, social care, commissioning and so on. Participants did not need to have experience of working together as a team to date, but they needed to be committed to working together on a common transformational issue of local strategic importance.

Through the design and content of the programme I anticipated it would build significant new capabilities and, at the end of the programme, the personal outcomes would be that participants would be able to:

- describe the latest thinking on large-scale change and how it can be applied to address their local large-scale change challenges—based on the taught theory and literature provided (**Appendix 28**)
- demonstrate understanding through ‘real time’ application to their specific large-scale change problem to affect change—based on applying the learning to their real time large-scale change project and the coaching
- identify the most relevant change tools, models and frameworks to support effective implementation of the key stages of the ‘large-scale change model’ within their own local context—as a result of combining the theory with implementation on the ground supported by some coaching sessions

- develop reflective practice and improve their own ability to act as a leader of large-scale change—as a result of the discussion sets, workshops, group work and coaching sessions
- identify the most effective strategies to sustain themselves as change leaders in and across a complex system—as a result of learning about the challenges they would face and how they might counter them
- develop the higher large-scale change knowledge and capability required to effectively apply and adapt the principles in a variety of contexts—as a result on the combination of all the elements of the developmental programme.

The evaluation of the Leading Large-scale Change Programme conducted by the Institute for Employment Studies (see **Appendix 25** for the design) stated that these objectives had been achieved. The survey data suggested that people felt better equipped to lead large-scale change and more confident in their leadership style. This was well supported by qualitative data from interviews and case studies.

The curriculum (**Appendix 24**) was delivered through a range of approaches to 25 senior teams. In its initial six-month phase it included:

- three workshops (i.e. full-day, team-based learning and activities)
- six web seminars (i.e. 90-minute, expert-led teaching and discussion)
- four discussion sets (i.e. 90-minute, facilitated topic-based discussions for mixed groups)
- team coaching (i.e. up to three 90-minute sessions with an expert coach)
- access to a range of support materials (i.e. guides, templates and literature).

The basic programme structure is shown below in Figure 3:

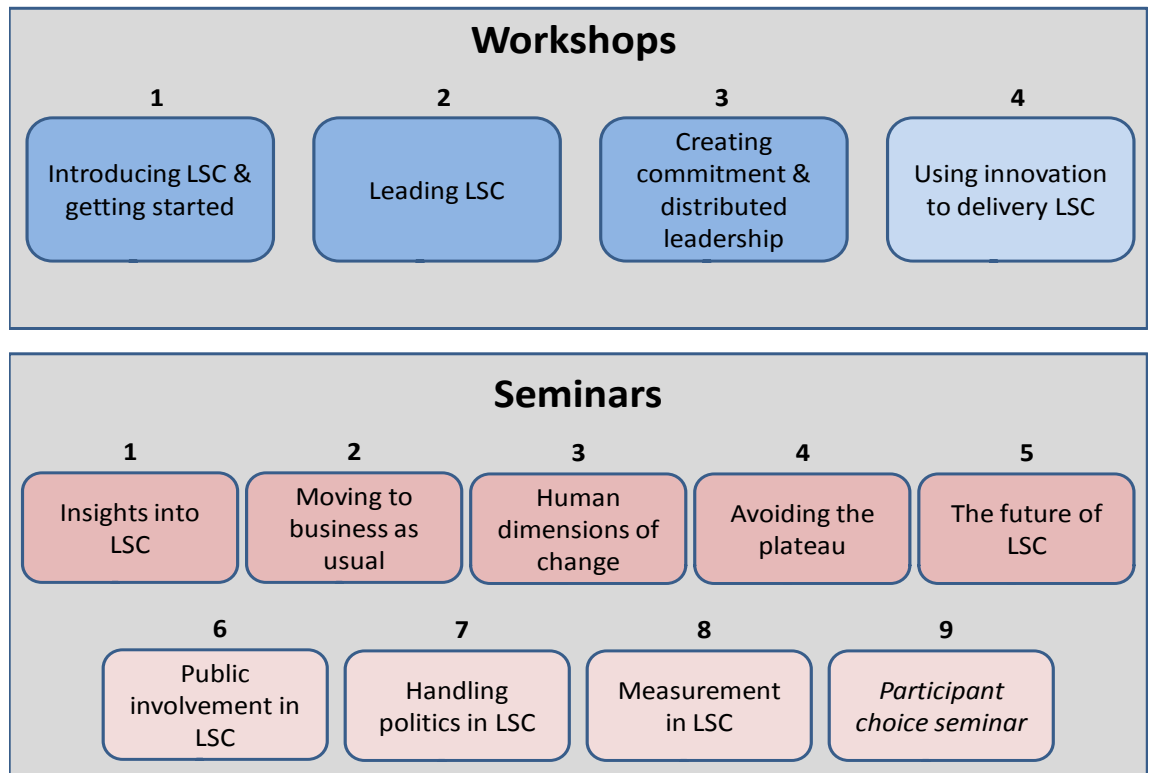


Figure 3: LSC programme structure

In the programme we used the Model of Large-scale Change (Figure 3) to embody the two key concepts of emergence and influence and how they impact upon transformation in social systems. At its centre are the multiple cycles of engagement and change. In these cycles people are actively attracted to the transformation both by framing it in light of their interests, using some of the approaches around ‘public narrative’ as described by Ganz (2010) and communicating evidence of success. Here, these cycles of change replace more conventional rigid linear planning as a way to both recognise emergence and to foster a growing understanding of the system and the people within it.

Public Narrative

I was familiar with the management of change approach used in the NHS, for instance organisational behaviour, leadership and management studies, clinical/medical audit, improvement science, with a century-long academic

tradition. My work on reviewing 'organising and mobilising' approaches showed they delivered change through campaigns and social movements, so I explored what could be learnt from popular, civic and faith-based mobilisation efforts which also had a tradition of a hundred years but were not utilised in healthcare in the UK. When reflecting on how to achieve large-scale change in the NHS I explored the work done by Ganz (2010). A key element was the power of storytelling with a purpose, used to reveal your values and those of others to gain comment to the change. I, along with others in the NHSI, thought this might address the high failure rate in change programmes. This was identified in 1995 by John Kotter, who stated that only 30 per cent of change programmes are successful. In 2001 Daft and Noe confirmed, 'there is considerable evidence of high failure rate in projects sustaining their efforts (as much as 70%)'. In 2004, PriceWaterhouseCoopers identified that only 29 per cent were successful. This hypothesis of tapping into values and using storytelling to improve success rates was also backed by a range of other views on the impact of leadership and storytelling that you need both aspects of change management discussed below.

Table 3¹⁹ shows two aspects of change that describe the intrinsic and extrinsic elements that should be considered when implementing change and using public narrative to address the physiology of change:

¹⁹ Developed by Bevan and Crump; can be found at http://www.changemodel.nhs.uk/pg/cv_content/content/view/31819)

	Anatomy of change	Physiology of change
Definition	The shape and processes of the system; detailed analysis; how the components fit together.	The vitality and life-giving forces that enable the system and its people to develop grow and change.
Focus	Processes and structures to deliver health and healthcare	Energy/fuel for change
Leadership activities	<ul style="list-style-type: none"> • measurement and evidence • improving clinical systems • reducing waste and variation in healthcare processes • redesigning pathways 	<ul style="list-style-type: none"> • creating a higher purpose and deeper meaning for the change process • building commitment to change • connecting with values • creating hope and optimism about the future • calling to action

Table 3: Anatomy and physiology of change

From a Senior Leaders' development programme run by the NHSI, use of energy identified through a self-assessment questionnaire revealed the following about NHS senior leaders:

- 57% created a climate which is 'de-motivating'
- Only 12% created a climate that is 'inspiring'.

Further, there is a challenge around the messages that leaders promulgate: 'What the leader cares about (and typically bases at least 80% of his or her message to others on) does not tap into roughly 80% of the workforce's primary motivators for putting extra energy into the change programme' (Keller and Aiken 2008, p. 3).

Denning (2007) discussed that organisations focus more on facts and figures to influence change. Increasingly we have rediscovered the persuasive power of stories. Storytelling is the intersection of leadership and influence. In a story, the teller vividly brings a situation to life in a familiar context, using it to insert subtle influencing techniques; 'an appropriately told story has the power to... communicate a strange new idea easily and naturally and quickly gets people into

enthusiastic positive action’ (Denning 2007, p. 38). Stories such as gossip have the ‘viral’ traction and embed quicker into the fabric of an organisation than the messages contained in a typical PowerPoint presentation. Denning (2007, p. 205) described storytelling as ‘the ancient art of engagement and influence, fundamental in all cultures and a crucial skill required to master the art of the influence’—the art of influence that is so critical in large-scale change.

Ganz’s (2010) approach to storytelling (public narrative) has three key elements: the stories of ‘self’ (revealing your values), ‘us’ (connecting to others values) and ‘now’. The ‘now’ is the need to create a sense of urgency alongside a sense of hope for a vision. This links to Kotter’s (1995, p. 1) eight-step framework. Kotter advises those who would implement change to foster a sense of urgency within the organisation: ‘a higher rate of urgency does not imply ever present panic, anxiety, or fear. It means a state in which complacency is virtually absent.’ There is a need to communicate this constantly.

Hence, developing a strong narrative (story) around how cost improvement is delivered through quality in the NHS responds to: ‘the science shows that the secret to high performance... [is] our deep seated desire to direct our own lives, to extend and expand our abilities and to live a life of purpose’ (Pink 2009, p. 145). I consider that the most important first task in creating a successful quality and cost improvement strategy paradoxically is not to identify the size of the challenge or to work out which areas of service delivery offer the greatest opportunity for change. Rather, it is to create a deeper meaning in the challenge that lies ahead, to link the cost improvement programme to the higher purpose of the organisation or NHS system. This is the key to a clinically relevant case that makes both a rational connection and a connection to the values of those delivering the change as ‘more than 80% of our ability to save costs depends on clinical decision making’ (Brent James, Institute for Healthcare Delivery Research Intermountain Healthcare).

This thinking shaped elements of the Leading Large-scale Change Programme run from April 2012 and the NHS Change Model²⁰ launched in May 2012. Both include the use of storytelling as a critical motivating factor to engage and mobilise staff towards the change you are focused on delivering.

Evidence of Public Impact

See **Appendix 26**

(A sample of LSC literature reviewed to inform the curriculum: **Appendix 27.**)

My Reflections and Learning

Challenges to Establishing Teams to Deliver Large-scale Change

One of the challenges the Academy of Large-scale Change (2008) had faced was participants arriving with a lack of clarity about the large-scale change they wanted to bring about. They had not established a team to work with and were usually unclear about their scope and vision. This meant that their learning was impeded and clouded by other issues. In order to address this challenge the application form for this programme was designed to identify all these key issues (**Appendix 29**) and it had to be completed successfully in order to participate in this subsidised programme. We also arranged a coaching session (with each of the participating teams) prior to the commencement of the programme to ensure all the potential gaps had been addressed, so they could attend the first workshop and have the full benefit. Despite these attempts to prevent unprepared teams attending, we found that some teams and projects were not fully formed. A further complication was that several of the participating teams had a high turnover in membership. There was a variety of reasons: turbulence in the NHS system due to the major reform being undertaken by the government at the time, and as already discussed, pressure of the 'day job' overtaking this more strategic role were the main reasons.

²⁰ <http://www.changemodel.nhs.uk>

The perceived value of the programme was not the issue for attrition. We were careful to explore this and it was noted that other senior staff took the place of leaving team members. In adult learning it is stated that a receptive context is needed for it to be effective. I would add that you need a relatively stable context, in addition, as turmoil is distracting and disruptive and impedes learning. I reflect on the regular restructuring of the NHS conducted by successive governments. Several authors (e.g. Pedler and Aspinwall 1998; Dierkes et al. 2003) have highlighted how public sector organisations are increasingly vulnerable to radical government policies and I consider this a negative impact on the NHS and the organisations within it in becoming 'learning organisations', as defined by Watkins and Marsick (1993, pp. 8–9):

Learning takes place in individuals, teams, the organisation, and even in the community with which the organisation interacts... (it)... is a conscientious, strategically used process, integrated with a running parallel to work ... (which)... enhances organisational capacity for innovation and growth. The Learning Organisation has embedded systems to capture and share learning.

I suspect if structures and systems have little time to bed down due to regular restructuring of the NHS, it is difficult to be a learning organisation.

Challenges to Using Virtual Delivery

Virtual delivery—the webinars—took place after the face-to-face workshop to ensure there was a relationship with the now 'virtual' speakers. This had been a successful approach in other programmes. However, in this instance there was a lower uptake of some virtual elements (web seminars and discussion sets). This transpired to be a reflection of the context of senior NHS leaders. If you are busy and in demand, 'virtually' attending a lecture or discussion by sitting at your desk with WebEx, laptop and headset, especially when a recording is available, means your colleagues, staff and the participants themselves find it easier to respond to day-to-day pressures rather than protecting their virtual learning session. One promises to oneself to watch the recording later, but do not. Those who attended rated the sessions highly.

Challenges to Commitment

It is an important learning about senior adult learners that the day job can get in the way. Importantly, this was also reflected in their focus on their large-scale change. If participants were taking on this role in addition to their day job, the large-scale change elements were neglected in a classic case of the urgent vs. the important. To address this issue I would state that, if the NHS really wanted to tackle large-scale change, teams focused solely on that challenge should be established. This is further evidenced by the teams who had managed to deliver. They were established for the purposes of the large-scale change.

The same issue impacted on the coaching sessions, which were highly valued by individuals but, when the coaching was focused on a team, there was a lower uptake as the teams failed to organise their diaries. This was further reflected in the fact that the majority of these teams did not have regular meetings outside the programme they were attending, again having a further negative impact on their ability to deliver.

Balancing the Curriculum

Reflecting on the curriculum I feel that whilst the programme currently had a comprehensive approach to the 'intrinsic' (or behavioural) side of large-scale change there are some gaps that need to be addressed. I had taken this approach as it is typical for the behavioural aspects to be neglected in programmes as evidenced by the reasons for failure of change attempts, as evidenced by Keller and Aiken (2008), who state that change programmes fail due to attitudes and behaviour. However, the programme might have overcompensated and with consideration I think the following in particular should be added:

- 'extrinsic'/mechanistic elements of large-scale change e.g. greater coverage of programme management, governance, ROI etc.
- small-scale 'normal' change capabilities e.g. process mapping, PDSA, etc.

Recommendations for Future ‘Leading Large-scale Change’ Developmental Programmes

As deduced from personal reflections, participant feedback, the third party commissioned evaluation and reflective discussions with the small teaching faculty, programmes should:

- a) Retain a focus on teams with real projects and enhance the pre-programme assessment of suitability (e.g. through pre-programme discussion with applicants)
- b) Continue with a workshop-led model and sequence over the whole programme to increase continuity of interaction
- c) Limit workshop cohorts to 50 people (e.g. 5-10 teams) and continue to encourage faculty/coach interactions through the workshops
- d) Consider replacing web seminars by workshops, as preferred by these senior participants (or consider retaining web seminars and introduce an ‘in the classroom’ model)
- e) Remove discussion sets or replace with formal action learning sets
- f) Find ways to mandate or support participants in regular team meetings through the programme structure (e.g. regular workshops, fixed coaching sessions, participation criteria, sponsor requirement)
- g) Expand the programme materials to integrate with ‘extrinsic’ capability areas (e.g. programme management) and basic improvement skills (e.g. process mapping and PDSA cycles)
- h) Ensure each project has a formalised project lead potentially with more dedicated input (to ensure project leadership).

This learning is currently being reflected in the design of a newly commissioned developmental programme (2013) for senior leaders and managers of NHS England to build their capability to deliver transformational change in the NHS.

Key Points

Influence and Emergence in Transformational Change

It has emerged from my professional practice that relationships and hence people are central to large-scale change in healthcare and, I would suggest, in all change. People shape the vision, they deliver the change and they give life to the transformation as they adopt new mind-sets and behaviours. Unfortunately, they also provide many of the challenges that will be faced by those involved in leading change. As Davis Balestracci²¹ exclaims, ‘those darn humans! Change would be so easy if it weren’t for all the people’.

In research that focuses on professional and practice knowledge, transparency is required on the researcher’s ontological and epistemological position so the reader is clear about the lens researchers use as they explore, research, action and interpret professional contexts. Personal and professional backgrounds and interests influence perceptions, decisions, directions and actions. It cannot be assumed that there is some homogenous view. Such difference in the ontological and epistemological position of others is not clear in the work environment, making understanding and anticipation of responses to change a challenge. People generally do not expound or feel the need to explain their positions but some of it emerges in their responses to change. That is why appreciative inquiry and storytelling are so valuable. They respectfully draw out people’s positions and perspectives and the rationales for them. Change and improvement becomes a matter of convincing and persuading through listening, collaboration and reliable evidence.

In an NHS culture where the epistemological position is evidenced-based medicine and has become the norm, and double-blind randomised trials are the Holy Grail of evidence, with the medic’s view of the world elevated, NHS staff find change within

²¹ <http://davisdatasanity.com/my-services/public-speaking/#2>—an expression he uses in his workshops I have attended over the years.

such a social system more unpredictable than they would like. Cause and effect are often separated in time and distance. Changing a simple thing like a paper form that staff complete could have no impact or could be the key to unlocking a whole transformational change. Equally, it could be the thread that unravels the transformational change.

I have learnt that large-scale change is messy, so it means that traditional ways of managing change through planning and control are inadequate when it comes to transforming health and social care services. Planning has to be tempered by a recognition that unpredictable events will ‘emerge’ and may need to be responded to as a challenge or a breakthrough. Control through seniority has to give way to recognising hierarchy but leading through influence. I would say to those in my profession that our focus needs to move to building commitment to the bigger picture, the vision, rather than enforcing compliance. I think this is particularly difficult in an NHS managed through target achieving, risk adversity and a strong culture of macho performance management.

To lead large-scale transformational change I think these two words are critical—*influence* and *emergence*—as they shape much of what it means to lead and deliver large-scale change.

I would recommend as one begins leading transformational change to keep thinking ‘*influence and emergence*’ and bear the following in mind which reflect the model for large-scale change (Figure 3):

- start thinking ‘cycles’ instead of linear plans—these allow for emergence and help the change agent to maintain a focus on creating widening engagement
- keep reframing the messages about shared vision and goals to build commitment. What motivates and inspires the change agent may not work for or be shared by others

- assume the *only* way to get others to participate in change is through influence—control is an illusion
- get started and see what happens—do not try and plan it all! Keep eyes open for opportunities that emerge to move further and faster
- let everyone know what is happening—stories of progress spark interest and involvement.

In large-scale change, relationships are critical to success. Reflect on ‘keep your friends close and your enemies closer’ (attribution is disputed between Sun Tzu, Machiavelli, Petrarch or Coreleone, who brought into popular usage through the 1974 film, *The Godfather Part II*). In large-scale change I would suggest, ‘keep colleagues close and keep even closer to the people across all those departmental and organisational boundaries’. A colleague, Andrew Singfield, suggested that those leading large-scale change should become expert ‘system watchers’. I agree that large-scale change needs time to reflect and observe what emerges, as change agents’ actions (or those of others) create ripples across the system. If they are not what the change agent is seeking, what can be done to counteract them?

My Final Reflections on Delivering Transformational Change for Improvement in the NHS

In this final section my passion comes out. I use 'I' and 'we' and 'you'. I sound at times as if I am orating at Hyde Park Corner, but my passion is well balanced by the work I have been involved in and the impact the innovations I have led have had. This last section of this context statement gives me the space to give my informed opinion about what might work after these years of researching, designing and implementing change.

In this new NHS of 2013, with a dramatic change to commissioning healthcare with the abolition of PCTs and a new NHS Commissioning Board (NHS England), the power of bringing about transformational change lies in the hands of clinicians in CCGs. What is the thread for transformational change that joins together good commissioning and provision of healthcare for the future of the NHS?

There is a considerable amount of guidance on how to commission, and likewise an ocean of good practice for providers of healthcare. But does this overwhelm NHS staff? I do not know if they have the capacity to explore this bank of literature and I suspect many lack the inclination. Knowles (1973/1990) described the pre-conditions for adults to learn, but this issued guidance fails to recognise this. My most effective programmes teach people the theory *and* support the implementation of it in real time. I speculate that issuing publications rarely brings about change. Being performance managed on it brings about some change but through compliance not commitment.

Leading with a Vision

Should there not be a focus on a vision to draw people, like iron filings to a magnet, to a better way of delivering healthcare? In my teaching role on the Leading Large-

scale Change Programme, I support the notion of engendering commitment and not of compliance. An inspiring vision is important, but it needs to be an inspiring vision in practice, in behaviours as well as in terms of articulation, then others can become self-directing as they work towards the shared vision.

Ganz (2009), a leading expert on community organizing,²² believes by reaching out to form a community through ‘commitment groups’ one must have the foundation of a shared purpose and this needs to be clear, consequential and challenging, a shared purpose to engender support for change in identified in the NHS Change Model.²⁰ This links with the idea of a shared vision providing direction.

Leaders need to translate the visions into objectives. There needs to be clear objectives aligned with the objectives of the organisation in each directorate, in each department and in each team. These objectives need to be limited in number. In my experience we do not want or need and cannot cope with twenty or thirty objectives—I suggest maybe six or seven clear, priority objectives. One of the characteristics of our current healthcare service is that there are so many priorities that there *are* no priorities. The objectives must be challenging. Research on goal setting demonstrates that the motivational aspect of goals is fundamentally affected by how challenging those objectives are. In other words, it is no use setting objectives that are going to be achieved anyway. They also need to be measurable so that participants in the change can have feedback.

Reflections on Leadership

I think we need a new leadership model. Ganz (2010) talks about ‘an interdependent model of leadership’ to bring about a shared goal that is urgent and addresses an intolerable condition. Ganz shared:

²² An organiser of political campaigns, unions and non-profit groups, Ganz is credited with devising the successful grassroots organising model and training for Barack Obama’s winning 2008 presidential campaign.

nothing is more important than coming to terms with this fundamental question: are we willing and able, to let go of enough control to let others lead? Can we let go of enough control to allow our organization to build the power that can only be achieved by letting it grow leadership rich? (Ganz 2010)

The concept of interdependent leadership is echoed by Malby and McKenzie (2012)²³ in their references to 'shared leadership'. Shared leadership means groups taking on a range of leadership activities rather than having all decisions focused through a single hierarchical leader. Specific tasks or work streams are taken on by whoever is the best match: 'Shared leadership tends to allow more fluid and nuanced responses that are more appropriate to the problem.'

As I have mentioned earlier, I learnt that to lead transformational change two words are critical—influence and emergence. They will shape much of what it means to lead and deliver large-scale change. Yet currently the culture in the NHS is strongly hierarchical, tribal and heavily performance managed through targets. I think there is little tolerance of emergence as the NHS is bureaucratic, rich in documentation to illustrate plans and the progress of change management. The traditional method of command and control is more prevalent than working through influence due to a low tolerance of risk, thus counteracting the idea of shared or dispersed leadership. This challenges the 'cross-organisational boundaries' working that is required to bring about the system reform necessary for the NHS to improve quality and use fewer resources.

In the 'Leading Large-scale Change Programme' I talk about the need for 'distributed leadership' (Hartley and Allison 2000; Spillane et al. 2001; Gronn 2002). Some literature describes it as dispersed leadership, often working across organisation boundaries. The key to distributed leadership is creating the

²³ <http://www.hsj.co.uk/resource-centre/leadership/take-the-first-steps-to-sharing-responsibility/5050472.article?sm=5050472>

conditions for independent decisions by people who are committed to the vision. It is not just about choosing leaders and delegating. Effective interdependent, shared or distributed leadership is united by a shared purpose or vision, and is challenged by giving up control to the newly empowered leaders of the desired change. Can senior leaders in the NHS 'let go', or is there a fear of retribution in this heavily performance managed NHS? The recent Francis Report about the failings at Mid-Staffordshire Hospital²⁴ makes 'letting go' even harder. I recommend leaders have a clear vision of the way forward, developed with their partners, staff, providers and commissioners and have the confidence to empower others to take the necessary steps to implementing the vision.

Leading large-scale change is emergent and messy, requiring strong influencing skills to work successfully across a range of organisational boundaries with the need for mutually-reinforcing changes in multiple systems and processes. So it takes a long time. Large-scale change addresses the challenges in the 'difficult box'. I think fast turnover of leaders in healthcare means the items in the difficult box are rarely addressed. This contributes to these areas being neglected and perpetuates the status quo. This high turnover is often seen in challenged organisations where the need for improvement is so strong. Here, leadership is required that can create a shared purpose and strong vision of a better way forward. In order for this to happen the leaders need time to establish a new culture that embodies a passion for improving healthcare. They need time to make changes in the complexity of health and social care systems, otherwise the challenges in the difficult box will not be addressed. The Francis Report suggested it was the 'hard to change', 'big' things that needed to change. I think leaders need to be allowed time to do this and be supported in this potentially lonely role. I suggest improvement is not brought about through repeatedly restructuring or changing leaders, thus tampering with the 'anatomy' of the NHS. Instead, there is a need focus on the 'physiology' of the NHS—its culture—and support and guide leaders to do this.

²⁴ <http://www.midstaffsinquiry.com/index.html>

Reflections on Partnership Working

Commissioners are required to evaluate what is needed for the population, then to decide carefully how to use their budgets to best effect for their community, spend those budgets and then ensure that the providers deliver what they agreed to deliver. This is enshrined in the commissioning cycle. But what if commissioners are not the experts in what they are commissioning? In other sectors, the emphasis is on finding ways to make 'partnership working' work. For example, the commissioners of products such as fashion items do not need to know how to deliver the best manufacturing process, but they do know what their customers want and need. These commissioners and providers sit down together and learn about each other's needs and priorities, navigating their way through the complexities that a partnership relationship entails. Perhaps the guidance for commissioners should focus on partnership working, not competition.

Reflecting on Oshreys' (2007) definition of partnership, in my experience of troubled systems and organisations I have often found that key individuals are not talking to each other, sometimes because relationships have broken down but often because those key individuals are 'busy running the show' and are addressing the urgent whilst neglecting the important. The fact is that *failing to nurture these key relationships is not a neutral act; it is an abdication of responsibility* and it can lead to an assumed adversarial position. An initial act of getting key people into a room to discuss the goals and challenges can be enormously beneficial. Weisbord and Janoff (2007) run three-day planning workshops that enable people to cooperate in complex situations, including those of high conflict and uncertainty; I have run similar workshops called 'accelerating learning/change events'. We both have a ground rule; *the whole system must be in the room*. This is a critical factor often neglected. Miss out a key stakeholder and you miss a chunk of the story. Or worse, create an outsider blamed for the system's problems.

Reflections on Partnership and Shared Leadership

As responsibility for system leadership passes to CCGs, local authorities and other bodies brought together in Health and Wellbeing Boards, distributed leadership will be important. The reality is that, in order to deliver the kind of large-scale change needed to address the challenges of the NHS, this dispersed leadership model needs to be adopted. Gone are the days of the dictator or the 'lone ranger'. *An effective partnership approach should lend itself to dispersed leadership.* With a clear direction and the benefits of understanding each other, efforts from different stakeholders can be aligned to nurture the way healthcare services grow and flourish. Excessive micromanagement or control can make way for a transformative approach to reach that magical Eden.

Creating this proposed garden is not without its challenges. In the commissioner–provider relationship it is possible to see partnership working and shared leadership at the opposite end of a pole (a polarity) to the performance management expected of a commissioner. Both partnership working and performance management exist because they have positive benefits, fulfilling specific needs. However, take either to the extreme and you risk tipping into collusion or dictatorships. The trick is to learn to take the best from both worlds as described by Johnson (1996): obtain the gains from partnership working and the gains from performance management, without experiencing the downsides of either. It seems like a paradoxical orientation to change, but it is possible through commissioner–provider partnering and holding each other to account, which requires effort. Traditional methods that allocated some commissioning staff to be the 'friends' of providers, supporting improvement activities while other staff wielded the sticks of performance management, created fertile conditions for the downsides of both poles, and confusion, anger and inertia reigned.

Reflections on the Future

In my years in the NHS I have seen bursts of energy and change fatigue, the latter having increased considerably in recent years. Change should be about releasing energy, maintaining it and is largely self-directing, guided by a strong vision. It is values based not logic-based; it is about effecting an equilibrium between affect and cognition.

I am an optimist, a 'glass half-full' kind of person. I should like to think that the reality of a large public body using 18 per cent of the gross domestic product (**Appendix 30**), where every member of society engages with the NHS and it being so closely linked to politicians and all the cyclical repercussions of governments, will not prevent the kind of change being implemented in the way I am suggesting. However, even to hold such an attitude and to operationalise a new approach can be exhausting and frustrating. This has led me to reflect on other options.

Maybe the only way productive partnerships with committed relationships working towards a shared vision can work in the NHS is in a health service independent of the politicians and funded through insurance. Maybe then healthcare in England would have the courage to foster the culture of innovation in which the dimensions of organisational culture that support innovation are supported; the widely shared knowledge, the inspiring goals, collaborative team working—relationships, with recognition and rewards for innovative approaches and a tolerance of risk taking. Maybe then we could rescue the NHS from some of its current challenges. I am aware of the number of 'maybe's.

In 2005 I led a team looking to identify what the best hospitals did with regard to high volume pathways. Trans-disciplinary teams visited the best hospitals and the worst. I asked the teams to come back with tangible 'to do's' for other organisations to be able to replicate. Several months later they reported back—'you are not going to like this, Julia, but it appears to be all to do with leadership and the culture they establish'.

In an appreciative stance, rather than persistently criticise NHS leaders, ways need to be found to support and develop their relational and leadership skills. But before then, the appointments system needs to be looked at with a refreshing list of personal as well as professional attributes such as negotiation, resilience, presence, consultative and courage. We need a more forensic exploration of previous leaders' roles and behaviours to ascertain their capacity for and openness to being supported in establishing a new culture, in which transformational and enduring change can take place. The NHS needs to become a learning organisation so that another Francis Report is not needed.

I have reflected on how my practice has changed, but what of me? I do feel frustrated that there is so much political influence in the NHS. A look at some of the best healthcare organisations in other countries reveals organisational and leadership stability that allows sufficient time to work on the many other factors that contribute to delivering high quality care. However, this frustration has kept me wedded to the NHS, helping to address its problems. It has generated an interest in politics and an understanding of the importance of politics without ever discounting the possibility that there may be a better way.

I have become experienced and confident in designing large national programmes and know they do make a difference. I now find working at a national level is almost a compulsion for me as it provides the opportunity to influence positively. I would describe myself as more critically aware, worldly and broadminded, with a sounder understanding of cultural issues.

This critique of my works has only served to confirm and affirm my passionate belief in team work; the sum is better than the parts. I rather suspect I am now less tolerant of hierarchy and prejudice. Working nationally and internationally means the parochial Julia has long since gone.

Word count: 28972

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Appendix 1

Commission for Health Improvement ratings: Ambulance Trust overview

Source:

http://www.chi.nhs.uk/Ratings/Trust/Overview/ambulance_overview.asp

All Ambulance Trusts have been assessed on their performance during 2002 / 2003 against a limited number of key targets and a further range of indicators. Key targets are the most significant factors in determining overall performance ratings this year. The ratings methodology for Ambulance Trusts is similar to that for acute Trusts except that the set of key targets and indicators is smaller, reflecting the particular range of services offered by Ambulance Trusts.

Key targets

- category A calls meeting 14/19 minute target
- category A calls meeting 8 minute target
- financial management
- Improving Working Lives

Performance against targets is assessed in terms of whether the target has been achieved, whether there has been some degree of underachievement or whether the target was significantly underachieved. Trust performance is considered to be of concern if there are:

- several targets with some degree of underachievement
- one or more targets against which there has been significant levels of underachievement
- a combination of both

Indicators

The broader range of indicators makes up a 'balanced scorecard' to refine the judgement on ratings. This balanced scorecard approach allows a broad range of areas to be measured within a single methodology. Trusts with high performance ratings therefore have to do well against a rounded set of indicators.

The indicators have been chosen to provide a balance across the clinical, patient, and capacity and capability focus areas outlined below:

Clinical focus

- clinical negligence
- thrombolysis protocols and procedures: training of paramedic staff

Patient focus

- category B/C calls meeting national 14/19 minute target
- GP urgent calls meeting national 15 minute target
- patient complaints procedure

Capacity and capability focus

- fire, health & safety
- information governance
- sickness absence rate
- staff opinion survey

For this year, clinical governance scores have not been incorporated into star ratings for Ambulance Trusts, who have only recently adopted clinical governance principles. CHI does intend to reflect clinical governance assessments in next year's star ratings.

Indicator listings for Ambulance Trusts

Comparison across all indicators

Key target	Results
Category A calls meeting 14/19 minute target	Results
Category A calls meeting 8 minute target	Results
Financial management	Results
Improving Working Lives	Results
Capacity and capability	Results
Fire, Health & Safety	Results
Information Governance	Results
Sickness absence rate	Results
Staff opinion survey	Results
Clinical focus	Results
Clinical Negligence	Results
Thrombolysis protocols and procedures: Training of paramedic staff	Results
Patient focus	Results
Category B/C calls meeting national 14/19 minute target	Results
GP urgent calls meeting national 15 minute target	Results
Patient complaints procedure	Results

Appendix 2

Improvement Partnership for Ambulance Services

The following summarises IPAS's main programmes of work and its achievements.

The IPAS Streams of Work

(i) Leadership Development Portfolio

There were already lots of good development opportunities being offered to all Trusts by different teams within the Modernisation Agency; however the targeting of Ambulance Trusts for their participation or a particular focus on them did not exist.

To avoid duplication of effort, a waste of resources and for speed of delivery, existing programmes pertinent for Ambulance Trust staff were pulled together mainly from the Leadership Centre's Executive Development Portfolio and the Coronary Heart Disease Collaborative and repackaged to target Ambulance Trust participation. IPAS funded places for staff from the zero and one star challenged organisations.

- **The IPAS Senior and Middle Managers Leadership Development Programme (SaM)**

Through the Learning Exchanges held in November 2003, discussions with several stakeholders and the work conducted by the Performance Development Team, it became apparent that there was a development gap for ambulance senior and middle managers. I ensured IPAS filled this gap by tendering and commissioning an external provider to design and deliver the first national leadership development programme for senior and middle managers – the IPAS SaM.

I ensured that the design phase of the programme, which was targeted towards the zero and one star challenged organisations, involved visits

to each of the Trusts involved to ensure the programme was relevant and tackled the real issues and pressures faced by staff. The programme consisted of two, three-day residential modules for senior managers from a mixture of Trusts and the same for middle managers. IPAS fully funded the programme for six middle and six senior managers from each of the target organisations (14 Trusts in total) at a cost of £441,000, almost half of the IPAS budget. The programme commenced in April 2004 and was delivered by July 2004. Some Trusts negotiated extra places and nearly 200 ambulance staff completed the programme. In addition, two staff from each of the organisations (one senior and one middle manager from each Trust), were trained as learning facilitators in September 2004 with the aim of ensuring the learning gained through the programme was utilised by their Trusts and built on through these staff running 'organisation think tanks'.

Feedback from the programme was extremely positive (see **Appendix** for extracts from the IPAS S.a.M. evaluation summary).

It was perceived so positively in the ambulance world, I received requests to run the programme for the remaining Trusts who were not eligible and for junior managers. IPAS did not have the funding to support these requests.

(ii) Performance Improvement Networks

The traditional Ambulance Trust structure combined with geographical and cultural influences has meant that staff from different Trusts rarely discussed national or local issues, or their Trust's responses to them. The idea of the Performance Improvement Network (PIN) was to develop communities of practice along the lines of an action learning set, to encourage debate, discussion, networking and the sharing of good practice whilst tackling real and current issues that are affecting the ambulance service.

It was decided to offer the IPAS PIN to directors of operations as they have key responsibilities and knowledge about Trust performance and are second in line to the chief executive in terms of seniority (and chief executives are offered a wide range of support within the Leadership Development Portfolio).

Four regional sets were established and attended by 29 of the 30 directors of operations. The sets are organised by IPAS in venues provided by Trusts or other NHS organisations and run by professional facilitators commissioned by the Modernisation Agency at a cost of £30,000. The first meetings took place in February 2004 and subsequent meetings ran every eight weeks. Due to the popularity of the programme, I agreed to fund additional meetings for each of the sets until January 2005 as well as an end of programme event that the directors of operations were keen to attend to consolidate and share the learning that had taken place in all four sets.

There was clear evidence that this process has had positive outcomes. For example, when the recent change occurred to localising the Category C target,²⁵ the North West IPAS PIN worked closely together. Below is an extract from correspondence from GMAS to their SHA:

"Greater Manchester Ambulance Service proposal outlines incremental changes in the management of Category C incidents, including changes in

²⁵ Ambulance responses are split by category; A (immediately life threatening) B (serious but not immediately life threatening) or C (not immediately serious or life threatening). For Category A incidents, the service has a target of an emergency response arriving at the scene within eight minutes in 75 per cent of cases, and a fully equipped ambulance, if required, to attend within 19 minutes within 95 per cent of cases.

the performance standard. The approach has been developed in conjunction with neighbouring Ambulance Trusts Lancashire, Mersey and West Yorkshire as part of the Improvement Partnership for Ambulance Services (IPAS) northern group.”

I asked the facilitators to put in place an action plan to enable the sets to be self-sustainable after January 2005 so that any sets wishing to continue could do so without the support of a facilitator. I had feedback from all sets confirming they had made arrangements to continue the sets using their own resources.

Although the feedback from Trusts has been very positive, I conducted a formal evaluation of the programme involving interviews with a random selection of Directors of Operations and their chief executives in November 2004.

Clinical Governance Leads

As the IPAS PIN model has worked so successfully for the Directors of Operations, I decided to apply the same model to an area that Ambulance Trusts have been struggling with in the hope that the model will achieve similar good results.

The four regional sets for Clinical Governance Leads commenced in September 2004 and ran until March 2005. As we utilised Trust or other free venues and the sets were run with the assistance of a Modernisation Agency staff member trained in facilitation, the costs of the programme were minimal (i.e. for lunch and refreshments only), thereby demonstrating that this approach could be run with low costs and benefiting key individuals nationally. Initial feedback from those who had attended the sets has been very positive.

Patient and Public Involvement/PALS Leads

See Section 4.2 Events below for information on how IPAS have initiated this process for these key individuals.

(iii) Good Practice Guidelines

I produced the following three documents:

- ‘Driving Change’ Good Practice Guidelines for PCTs on Commissioning Arrangements for Emergency Ambulance and Non-Emergency Patient Transport Services.
(http://www.institute.nhs.uk/index.php?option=com_joomcart&main_page=document_product_info&products_id=259&cPath=67)
- Human Resource Guidelines for Ambulance Services – To Assist in the Delivery and Measurement of your HR Services from IWL to CNST (no longer available)
- Best Practice Guidelines on Ambulance Operations Management
(http://www.institute.nhs.uk/index.php?option=com_joomcart&main_page=document_product_info&products_id=260&cPath=67)

Reference groups were set up to design the content for all of the above documents to ensure there was input from all relevant stakeholders and that all issues were covered. Contributions from the stakeholders were collated and I wrote the draft document which was then distributed to a wider stakeholder group for consultation and ratification before the final product was produced.

The commissioning document was launched at a ‘Driving Change’ event on 16th September 2004 which was attended by Primary Care Trust (PCT) lead commissioners, representatives from SHAs, WDCs, Acute Trusts, emergency care network leads as well as Ambulance Trust representatives (300 participants in all).

There has been considerable positive feedback on the document. PCTs stated that it pulls together all the relevant information into one place and usefully highlights new ways of working and a whole systems approach. The demand for it has been such that we did a reprint. Further, I was approached by the NHS Confederation to run an event for PCTs in February 2005 to cover the content of the guidance; Taylor et al. (2004). The Human Resource and Operations Management documents were published in November 2004.

(iv) IPAS Affiliates

The IPAS Affiliates programme was designed to support the challenged one star Trusts (as the zero star already receive similar support from the Performance Development Team). The original proposal was to second staff from Ambulance Trusts to visit and act as consultants in the challenged Trusts struggling with particular issues. However, due to the shortfall in capacity in Ambulance Trusts this was not a viable option and I was forced to be careful to spread the requests for support.

The following are examples of the support the IPAS affiliates have provided and the impact they have had:

- One Trust needed a wide range of support from achieving key targets to handling human resource issues. The affiliates brokered local relationships resulting in improved relations with the SHA and commissioning PCTs and improved performance.
- Another requested support on major incident planning, 'demand and capacity', clinical governance and clinical effectiveness, contributing to the improved star rating of the Trust.
- Support has been provided to several Trusts regarding refining their control room procedures.

- Some Trusts or SHAs have requested support on commissioning models resulting in improved understanding of the local issues from both perspectives.

The affiliates also provided me with valuable expertise, access to their networks and assistance in the delivery of some of the IPAS work-streams, for example the development of the 'Good Practice Guidelines'. This 'affiliate' approach was an essential component of this large-scale change. It enabled working across organisational boundaries and provided credibility for the new leadership style promulgated, moving away from a command and control style.

Brokering of Relationships

As resources for the affiliates programme were limited but demand for this type of support was high, I frequently offered a more informal version of the programme to those requiring assistance. Essentially, this has involved me acting as a 'broker' either by putting individuals with particular experience or expertise in touch with those requiring assistance in that field or by negotiating the loan of staff for short periods of support (from the stronger Trusts to challenged Trusts). I also negotiated hands on support from PCTs and SHAs for Trusts. This was a key part of my role. It enabled competing organisations to collaborate for the first time and to become more outward focused.

IPAS Events

Organising events provided me with the opportunity to engage Ambulance Trusts and other key stakeholders whilst giving Ambulance Trust staff the opportunity to network, learn from good practice and share their experiences through a forum that may not be provided for them elsewhere.

(i) IPAS Events run include:

National Learning Exchanges

Learning Exchanges were held in London and Manchester in November 2003 to engage over 600 key stakeholders in the work of IPAS and gather knowledge about the current issues affecting Ambulance Trust performance. These Learning Exchanges informed the rationale behind many of the IPAS streams of work and activities.

Medical Directors' Development Day

A gap was identified for development support for Ambulance Trust medical directors. I had planned to utilise an existing contract the Leadership Centre had with Keele University. However, the provider failed to supply a viable programme for this group so I designed and delivered an extremely well-received development day for medical directors on 30th April 2004. This work subsequently developed into facilitated support for this key group of isolated professionals.

Driving Change Conference

As mentioned in the above section on Good Practice Guidelines, this event which took place on 16th September 2004 was designed to inform PCTs about how Ambulance Trusts could be commissioned using a whole systems approach to benefit the wider reforming emergency care agenda, and to launch the guidelines. The following comments are from the event evaluation forms:

- *"A really useful day – probably should be held more than once a year."*
- *"Overall very helpful."*
- *"Very, very informative."*
- *"The conference was well organised, good location & well attended. Informative, providing good opportunity to hear innovative work around the country."*

Patients Driving the Service Conference

Patient and Public Involvement was an issue highlighted by the Commission for Health Improvement (CHI) in their report on Ambulance Trusts as an area where improvements in engagement need to be made (the good work already being conducted was also highlighted). The 'Patients Driving the Service' event was run on 20th October, with assistance from the Modernisation Agency Patient Improvement Team, to an audience of PALS and PPI leads from 20 Trusts. The aim of the event was to provide the first national forum for the leads to network, share good practice and debate how improvements in engaging the public in the work of the service could be made. Participants were so motivated by the event that they vowed to set up regional network forums to maintain the momentum gained and look into avenues to host future national events. Comments from the evaluation forms included:

- *"Very worthwhile, just sorry that agency won't be around to run another day like this."*
- *"Thanks for organising the event, and giving us a nudge to take more action in future"*
- What were the high spots? *"Networking; not feeling alone; being comforted by sharing views and ideas – knowing we are all going in the same direction."*
- *"Hearing how other services operate, learning about PALS and making new contacts."*

Joint IPAS/Department of Health Ambulance Futures Think Tank event

This event was run on 17th November to enable key stakeholders to influence the Department of Health Ambulance Review Reference Group. Professor Sir George Alberti, National Clinical Director for Emergency Access presented his vision of emergency care in 2010 and several Ambulance Trust chief executives presented models that they are already

starting to employ within their organisations. Peter Bradley, National Ambulance Advisor to the DH also attended and answered delegate questions.

Delegates felt that the day was useful and that it achieved its objective of being a catalyst for debate. A number of the delegates were very positive and very keen to be involved in the future of ambulance services and felt that it was a great opportunity to have their voices heard.

(ii) External Events

As the profile of IPAS and of Ambulance Trusts grew, I was asked to be key speakers at various events run by other organisations. These included:

- ASA events including the National Conference on Thrombolysis held in January 2004.
- An SHA organised event on Alternatives to A&E in February 2004.
- CHD Thrombolysis Conference February 2004.
- A JRCALC conference in March 2004 and the national conference in November 2004.
- AMBEX July 2004 – IPAS attended as exhibitors and sponsors of an innovation award.
- National Performance Advisory Group for the NHS: National Patient Transport Modernisation Group Conference – October 2004.
- The National Institute for Clinical Excellence (NICE) Conference in December 2004.

In addition, I was invited to speak to the Paris Embassy, Welsh Assembly and New Zealand Ambulance Group, amongst others.

Project Sponsorship

I was keen to sponsor innovative projects that have the vision to benefit the ambulance service as a whole. I had appreciated from my Masters study that rewarding innovation was a key factor in supporting a culture of innovation. Three projects have received IPAS support, these were:

(i) National Data Warehouse

This initiative was championed by East Anglian Ambulance Service and was brought to my attention thorough the regular IPAS Performance Monitoring Meeting. The idea was to engage the support of all Ambulance Trusts for a national database (which is compiled using downloaded Trust CAD data) to enable monitoring of individual, regional or national performance. As I realised that the data warehouse would not materialise until after the end of IPAS, a project board was set up to identify a new host to sponsor to project and to formulate a project plan to progress the development. The ASA has agreed to host the development of the project.

(ii) Research into Key Performance Indicators

Two Shires Ambulance Trust were working with Cranfield University to develop evidence based ambulance service key performance indicators. IPAS has contributed £10,000 to this research which in time is envisaged could link with the above mentioned data warehouse project.

(iii) NHS Information Authority Performance Dashboard

Essex Ambulance Service, with the support of the Performance Development Team and the NHS Information Authority are piloting the development of a 'dashboard' that will be able to provide live and up to the minute data on performance. Again it was envisaged that this project would contribute towards the refinement of the data warehouse.

Communications/Publications

Prior to IPAS, Ambulance Trusts had not been efficiently involved in communications around issues that equally affected them as well as other staff groups and sectors. I raised the profile of Ambulance Trusts through its activities and successfully negotiated inclusion of Ambulance Trusts in relevant communications. For example, in December 2003, the Modernisation Agency Allied Health Professionals (AHP) Bulletin ran its first article for paramedics.

- **IPAS Website (www.modern.nhs.uk/ambulance)**

The website has been developed to be a central point of information for Ambulance Trusts. As well as providing access to all IPAS developed resources (i.e. the good practice guidelines, delegate information and presentations from IPAS events), the site includes links to relevant and useful tools, information developed by the DH, Modernisation Agency and other organisations. There was also a section where innovative ideas developed by the service are highlighted and shared as examples of good practice.

- **Health Service Journal (HSJ)**

The number of ambulance service related articles in the HSJ increased and as result I was frequently contacted for views on topical issues or to respond to articles that were due to appear in the Journal. IPAS funded an Emergency Care supplement on the 22nd January 2004 to raise the profile of Ambulance Trusts. In addition, I sponsored the first ever Emergency and Unscheduled Care Category of the HSJ Management Awards. The award was judged by me, the chief executive of the ASA and Professor Sir George Alberti, National Clinical Director for Emergency Access, and the winner was announced at the awards ceremony that took place at the London Hilton Park Lane on 15th November 2004.

- **Ambulance Today**

'Ambulance Today' a professional journal ran a six-page article about the work of IPAS in its December issue. The article included feedback and comments on the work of IPAS from chief executives and Professor Sir George Alberti.

- **IPAS Update Bulletin**

This email bulletin was produced on a regular basis and includes features on up and coming IPAS events/development opportunities with links to new and relevant information. Back copies can be found on the IPAS website.


- **Contributions to Other Bulletins**

I was regularly asked to contribute articles on the activities of IPAS and feedback from IPAS events for the DH Emergency Care Bulletin, MA Chief Executive Bulletin, and AHP Bulletin amongst others.

Appendix 3

Improvement Partnership for Ambulance Services Publications

Authored and or edited by Julia R A Taylor

		
<p>The Improvement Partnership for Ambulance Services – A Guide</p>	<p>Best Practice Guidelines on Ambulance Operations Management See Appendix 6 for an extract</p>	<p>‘Driving Change’ Good Practice Guidelines for PCTs on Commissioning Arrangements for Emergency Ambulance Services and Non-Emergency Patient Transport Services See Appendix 4 for an extract</p>
		
<p>Human Resource Information for Ambulance Services. To assist in the Delivery and measurement of your HR services from IWL to CNST See Appendix 5 for an extract</p>	<p>Taking Healthcare to the Patient* Transforming NHS Ambulance Services: Report on the outcome of a strategic review of NHS ambulance services</p>	<p>http://www.radcliffe-oxford.com/books/bookdetail.aspx?ISBN=1857757424 Delivering Quality in the NHS 2005: Chapter under: ‘Developing and implementing NICE guidance. Improvement Partnership for Ambulance Services: what we do and how we do it.</p>

**‘Taking Healthcare to the Patient; Transforming NHS Ambulance*

Services’, was not authored by me it is evidence of the strategic review of

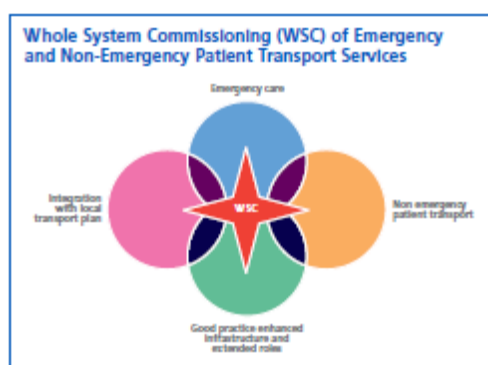
NHS ambulance services that IPAS significantly influenced its instigation.

Appendix 4

‘Driving Change’ Good Practice Guidelines for PCTs on Commissioning Arrangements for Emergency Ambulance Services & Non-Emergency Patient Transport Services

Extract

Executive Summary



There are consistent research findings which emphasise the need for more holistic approaches to transport planning as a central plank in combating social exclusion. These are driving major government policy initiatives relevant to this activity – [Appendix A and B](#).

PCTs are still coming to terms with their responsibilities for commissioning ambulance and related patient and service user transport services. These services have traditionally focused on access to acute care rather than the growing number of services based in primary care – [Section 4.1](#).

Because of the specialised knowledge required to commission ambulance services and because of the geographic scope of Ambulance Trusts it is strongly recommended that PCTs pool expertise in collaborative/lead commissioning arrangements rather than seeking to commission ambulance services as individual PCTs – [Section 4.1](#) and [Section 9.4](#).

In the context of National Standards, Local Action, PCTs have the opportunity to take the lead in ensuring the provision of integrated emergency care and non-emergency patient transport that is more

responsive to the full range of current needs and preparing for major policy shifts especially full implementation of Patient Choice – [Sections 4 and 5](#).

Financial arrangements are complex - funding is included in wider allocations and tariffs. Much of the current provision has been driven by financial considerations and individual provider Trust priorities rather than through integrated whole systems planning which is patient centred and maximises the part played by ambulance services within each Trust, health economy and social community. PCTs therefore need to audit the current position on both emergency care and non-emergency transport – [Section 4, 7.5 and 8.4](#).

There is a need to move away from negotiating a price for which Ambulance Trusts will achieve some or all of the performance requirements, to commissioning new ways of providing care and how unscheduled care as a whole should be provided. Historically, Emergency and Non- Emergency Patient Transport Services have been dealt with separately from each other and from the planning of other aspects of health and social care. These responsibilities are managed primarily through 31 Ambulance Trusts with all of them (apart from the Isle of Wight) being specialist providers covering widely differing geographical areas and populations. In many cases arrangements for PTS have been put in place through individual agreements to meet the needs of access to acute care rather than planning in a holistic way. Government performance requirements relate to the provision of emergency care. However, PTS constitutes a significant majority of patient and service user journeys and therefore of public experience of health and social care transport services – [Sections 6, 7, 8 and Appendix D](#).

Agenda for Change will impact more strongly on Ambulance Trusts than other parts of the NHS, particularly in increased salary costs and their training model, so PCT commissioners will need to have clear criteria for

evaluating options for delivering the full range of emergency care and PTS
– [Sections 4.4.2 and 5.3](#).

Performance against performance requirements is still improving but
2003/04 statistics show there is still significant room for further
improvement – [Section 6.2](#).

The (then) Commission for Health Improvement (CHI), in a summary of
2002/3 ambulance reviews, whilst highlighting a number of areas of good
practice, emphasised the need to adopt these more widely and also
distilled a number of concerns – [Sections 6.2.3, 7.4 and 7.5](#).

The infrastructure of ambulance services is complex. There are important
investment issues in each aspect which if addressed appropriately could
support modernising the services provided. It is divided into 3 elements:

1. systems;
2. staff roles;
3. means of response.

Investment in workforce training and development is an essential
underpinning to:

- maximise the contribution of ambulance services to both
emergency and PTS services through changing roles, such as
Emergency Care Practitioners, and changing practices, such as
delivering on scene treatment to reduce admissions to A&E
departments e.g. coronary care and direct admissions, as well as
diverting work to primary care services such as Walk in Centres and
Minor Injury Units;
- improve morale and change culture within Ambulance Trusts (See
Healthcare Commission Staff Surveys at

www.healthcarecommission.org.uk/NationalFindings/Surveys/StaffSurveys/fs/en?CONTENT_ID=4000125&chk=3p67/v ;

- Meet national and EU requirements around Agenda for Change, European Working Time Directive and Improving Working Lives - [Section 5.3](#).

Pressures to meet rising demand for both emergency and PTS services have been intensifying, creating a consistent and increasing pressure to modernise ambulance services. A national ambulance review is currently being undertaken led by a newly appointed National Ambulance Advisor. National Clinical Guidelines have been developed by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and are in the process of being adopted by all 31 ambulance services. IPAS will shortly be issuing a Good Practice Guide on Operations Management for Ambulance Services which describes the benefits of 'demand based cover'. (Visit the IPAS website for more information: www.modern.nhs.uk/ambulance) – [Sections 6 and 7](#).

Both the policy agenda and emerging good practice are emphasising the need for health and social care organisations to work effectively together to improve the delivery of emergency care. Emergency Care Networks are providing a vehicle for how this can be organised - [Sections 5 and 7](#).

There is evidence that use of emergency/unscheduled care services in acute care can be reduced significantly by increased access to the full range of primary care services as well as active management of care with people with chronic diseases/long-term conditions - [Sections 5 and 7](#).

In meeting the demands of rising workload in unscheduled care, ambulance services have much to offer if commissioners grasp the opportunities and bring them together with their acute, mental health and primary care colleagues to develop integrated plans, including addressing the needs of patients with chronic /long-term conditions – [Section 6](#).

The importance of PTS services in helping to reduce health inequalities and tackle social exclusion, achieving efficient booking of patient appointments, preventing 'did not attends' (DNAs) and in improving the whole patient experience needs to be reflected in the way PTS contracts are set and managed. There are many good practice examples across England which could be more widely implemented. The contribution of PTS needs to be given higher priority in health and social care planning to take advantage of new initiatives.

Issues include:

- treating PTS services as a core part of NHS and social care provision
- managing the length of the patient day
- financially rather than patient focused decision-making
- integrating planning within a wider transport strategy – contributing to the Local Transport Plan led by the Local Authority, in particular the new process of accessibility planning
- improving access to and convenience in using NHS services through patient centred planning
- utilising and publicising all voluntary, commercial, local authority and NHS services
- Publicising the Hospital Travel Cost Scheme. (The Prescription Pricing Authority, responsible for the publicity of 'Help with Hospital Costs' literature, including the Hospital Travel Cost Scheme, are launching a new promotion via the Patient Advice Liaison Services in Trusts, GP surgeries, pharmacies and appliance contractors. Telephone 0845 850 1166 for further information) - [Section 8](#).

It is clear that applying the effective commissioning strategies that are already established for other parts of PCT activities will assist them in commissioning emergency care and nonemergency patient transport.

New models drawn from this experience are therefore needed to commission emergency and PTS services. These should bring together all interested stakeholders in the delivery of health and social care to deliver services against clearly identified objectives and resource frameworks. This should be part of an integrated, whole system plan which focuses on patient needs and maximises the opportunities to redesign care pathways and modernise services - [Section 9](#).

Appendix 5

Human Resource Guidelines for Ambulance Services–To Assist in the Delivery and Measurement of your HR Services from IWL to CNST

Extract:

Guidance Notes:



The following document has been developed by the Improvement Partnership for Ambulance Services programme to assist Ambulance Trusts in the delivery and measurement of their Human Resource (HR) Services.

The title for each section mirrors the original IWL National Audit Tool, which has now been supplemented by an additional Audit Instrument to support organisations in achieving Practice Plus level of Improving Working Lives accreditation. Practice Plus is intended to be less prescriptive and hence is marked “suggested evidence” in the NAI. Also the Practice plus NAI contains only seven sections, as Staff Opinion Survey is included in the communications section.

Each section of the guide provides the ‘Need’ (i.e. the HR requirements of Ambulance Trusts) followed by the ‘Evidence’ required to show the achievement of the ‘Need’, relating to the delivery and measurement of each of the following:

- Improving Working Lives (IWL) Practice
- Improving Working Lives Practice Plus
- Commission for Health Improvement (CHI)
- Controls Assurance (CA)
- HR Performance Management Framework (HRPF)
- Investors in People (IiP)

- NHS Litigation Authority: Risk Management Standard for the Provision of Pre Hospital Care in the Ambulance Service (NHSLA Ambulance).

This tool provides a summary of the key requirements of these standards and a checklist for all actions required. It can also help determine key HR activity. For fuller details of national requirements, you should refer to the websites listed in the bibliography.

Section 9 HR Standards Criterion, provides additional information that does not form part of any on-going assessment of HR yet. However the topics form a vital element of the future workload of HR. These projects may be time limited but will need substantial consideration and resource time/money to implement effectively.

The references for the HR criterion are given on page 33 and the full document is available at www.info.doh.gov.uk/doh/rm5.nsf

Practice Plus assumes the indicators outlined in Practice are in Place. It seeks to assess embedded organisational culture and verify that those principles outlined by the Practice Plus indicators have been successfully introduced. However, evidence for the criteria from the NHSLA Risk Management Standard are taken from the April 2003 draft version, which is subject to amendment. It should be noted that the NHSLA Standard relates specifically to risk management, but the criteria contained within this document are those which are of relevance to the HR department.

Best Practice Guidelines on Ambulance Operations Management

Extract:

Introduction:



The revised National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08 sets out the framework NHS organisations and social service authorities are to use in planning for the next three financial years and the standards which all organisations should achieve in delivering NHS care. Appendix 1 of the National Standards, Local Action document, lists the existing commitments to be maintained and achieved by March 2005 (see Appendix 1 of this document). These include the ambulance response time measures for Category A and B.

Although it is recognised that the first priority for a Trust is to achieve and sustain the key target of responding to 75% of all calls categorised as immediately Life-Threatening within 8 minutes, performance improvement should be designed to address wider performance measures as indicated by the Core and Developmental Standards in the National Standards, Local Action document. These include improving clinical outcomes, particularly those, which are the subject of National Service Frameworks. In addition, there is a need to comply with Improving Working Lives, Health and Safety legislation, Controls Assurance and the Clinical Governance framework and other guidance.

This document aims to offer information and good practice examples in terms of Ambulance Operations Management and has been developed with generous assistance from Greater Manchester Ambulance Service, Hereford and Worcester Ambulance Service and Kent Ambulance Service. These organisations experienced a trend of significant service improvement of up to 40% by implementing the best practice cited in this

document to achieve and maintain the Category A 75% of calls within 8 minutes target.

In writing this document we recognise that all Trusts experience different challenges and constraints and that some issues may impact on an organisation's ability to implement the suggested good practice. However, evidence, some of which is presented in this document, has shown that implementing such good practice ideas can lead to real and sustainable improvements.

The contributors to this document from Greater Manchester, Hereford and Worcester and Kent, listed in Appendix 3, are happy to be contacted for further guidance on implementing these practices. These best practice guidelines are also covered in more depth in the System Status Management training programme, which is run by Keele University.

It is recommended that the information and good practice offered within this document be adopted within a wider whole systems change and a service improvement approach that responds to the Department of Health's Reforming Emergency Care agenda. 999 calls to ambulance services have increased over the years, (7.7% for the Service as a whole last year, however some individual Trusts, for example Bedfordshire and Hertfordshire, saw increases of 20%) and consequently this has had an impact on the demand placed on the Service and the ability of Trusts to meet targets. In June 2002, Margaret Edwards, Director of Access and Choice at the Department of Health, wrote a letter to all Ambulance Trusts entitled "Delivering the NHS Plan – Strengthening Accountability: Appropriate Use of Ambulance Services" which highlighted local action that should be taken in response to malicious and hoax callers and in response to 999 calls where sending an ambulance would be appropriate. This led to many Services, for example London Ambulance Service, developing a "no send policy" for such instances.

Through the modernisation of ambulance services and the introduction of new roles, Ambulance Trusts are in the position to respond to the increased demand more innovatively (for example, it may not be an appropriate response to take all 999 callers to A&E. Some Category C callers could be more appropriately treated at Walk in Centres, Minor Injuries Units or by links to NHS Direct etc.). Improved relationships with Primary Care Trust commissioners of emergency ambulance services and non-emergency patient transport services can also help ensure that ambulance services are commissioned and used appropriately. More information on this subject will be available in an IPAS document around commissioning which will be available in autumn 2004.

Improvement Partnership for Ambulance Services Senior and Middle Managers Development Programme Evaluation Report' - Summary

Background

Ambulance Trusts and ambulance staff have contributed significantly to the modernisation of the NHS and participated in many modernisation initiatives. However, there have been very few initiatives, which have been targeted specifically to support ambulance staff to modernise their own services.

The Improvement Partnership for Ambulance Services (IPAS) commissioned the Senior and Middle Managers Leadership Development Programme (SaM) in February 2004 after identifying the need for development at this level through the IPAS Learning Exchange events held in November 2003 and the initial engagements evidence reports conducted on the eight zero starred organisations by the performance development teams.

IPAS were tasked with designing and delivering a bespoke programme for the then fourteen zero star and CHI challenged organisations. The resulting programme consisted of 2 three-day residential modules for senior managers and separate modules for middle managers, which were designed with involvement from the participating Trusts. IPAS also ensured that leadership and management development tools and techniques suitable for both senior and middle managers were included in the programme.

The timescale for this crucial project was very short to ensure that support could be delivered before the next star ratings were announced in July 2004 as the Trusts requiring support may have changed. The programme therefore commenced in April 2004 and was completed, on schedule, in

mid-July. Two 'mop up' modules are being held in September/October for staff who were unable to attend their second module due to work pressures.

Introduction

The purpose of this report is to evaluate the effectiveness of the IPAS SaM in meeting the established programme and participant aims.

The programme aims for the Middle Managers were to enable the managers to:

- Understand and take responsibility for their managerial role
- enhance self-awareness and increase personal effectiveness
- manage relationships and partnerships within their teams, their Trusts and the broader health community

The programme aims for the senior managers were to enable the managers to:

- develop strategic thinking
- enhance self-management and personal effectiveness
- manage relationships and partnerships within the Trust and the broader health community.

Evaluation Methodology

Pre and Post Course Evaluation Questionnaires were designed to enable participants to comment on:

- their aims in attending the programme
- how they believed the programme would help them develop as a manager and leader

- how they thought the programme would impact their contribution towards improving organisational performance and enhancing patient care
- anything specific they expected or hoped to be able to do, or do better as a result of this programme.
- learning gained outside the formal programmes aims
- comments on programme content, trainers, teaching/learning, methods/delivery styles
- comments on venue, rooms, equipment, catering etc.
- any other comments.

They were also asked to comment on their proficiency in relation to:

1. the programme aims in terms of areas of knowledge and skill
2. the fifteen elements of the NHS Leadership Qualities Framework.

Comments on the above were collated from participants before and after they attended the programme.

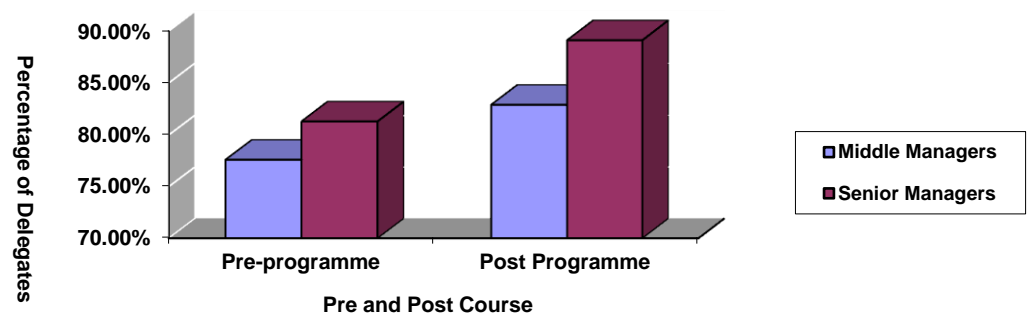
Findings

Attendance

The programme was designed for a maximum of 168 participants (i.e. 12 managers in total from the 14 zero and Commission for Health improvement (CHI) challenged Trusts). At the end of the formal programme, 140 participants had completed both modules. This can be broken down into 64 senior managers and 76 middle managers.

A further 24 participants (12 senior managers and 12 middle managers) were booked on the mop up modules that took place in September/October. Staff from Sussex, Dorset and WYMAS attended these modules. Final numbers to complete the programme are therefore 164.

Of those who attended the programme, the following percentage of delegates completed the pre and post evaluation form:		
	Pre-programme	Post Programme
Middle Managers	77.6%	82.9%
Senior Managers	81.3%	89.1%



Findings from Questions

Answers to the pre and post questionnaires and were rated against the fifteen elements of the NHS Leadership Qualities Framework

Middle Managers

The programme has clearly had a positive impact on people's perception of their own competency. When comparing people's evaluation of themselves before and after the event, significant increases can be seen in their competency ratings. The same is also true of people's self-belief; post event there was a marked increase in managers rating their self-belief in the 8–10 categories. Much the same pattern can also be seen in manager's feedback on awareness and self-management.

The programme has clearly motivated middle managers and given them the belief that they can carry out certain areas of their job more effectively. Even in areas such as 'drive for results' where pre-course ratings were high there was still an increase in people's evaluation of themselves.

"I have gained far more from the programme than I ever expected"

"I have started on the road to further development and feel that the IPAS course has been invaluable in starting the process."

"Understand my role as a manager and the responsibilities I have, whilst enhancing personal qualities and increasing my effectiveness."

"To help me develop, especially in light of the changes in the ambulance service"

"An excellent course from which I learnt a great deal, I now feel a more competent manager as a result"

"One of the most informative and professionally delivered courses I have taken part in"

"Excellent tutors and actors, very enjoyable course"

"The first management course I have attended in 20 years. Enlightening, enriching and encouraging"

A number (11%) of managers would like to learn more.

"When can I do more IPAS Training?"

Middle managers felt that more of their staff should attend these courses.

"I hope there will be an opportunity for more colleagues to attend"

"I thought it was excellent and would be very beneficial to young up and coming future management"

Senior Managers

A similar pattern to that of middle managers is visible in the feedback obtained from senior managers. Overall, the programme had a positive impact on senior managers. Their most popular response pre event to the question on their experience related to the programme was 'some experience'; post-event, the most popular response was 'significant experience'.

Whilst in most cases the post event responses were better than the pre event there are several cases where the ratings of nine and ten have not improved and in certain aspects the instances of people awarding themselves this rating is rare. For example on the question marked self-belief there was only a slight increase in people marking nine or ten. There were also some questions where percentages of people rating themselves eight, nine or ten dropped. This indicates either that the programme was less well received by senior managers or that they had overestimated their ability in the first instance. However, it should be noted that overall the feedback was still extremely positive.

“They support and challenge you in ways that I will try to emulate in my own arena”

“Very well led and supported. Thanks”

“Helped me by giving me the skills and techniques I need to improve my management style.”

“Now able to deal with any given situation in a more confident and reassuring manner”

“Changed me by giving me the skills to deal with the many and varied personality types I will meet through personal skills and reference material.”

“I have a new toolkit that can help me tweak and improve working practices.”

“It has given me an insight into my behaviour and style.”

“...has opened my mind to concepts and theories previously unconsidered.”

“Positively knowing my strengths and weaknesses”

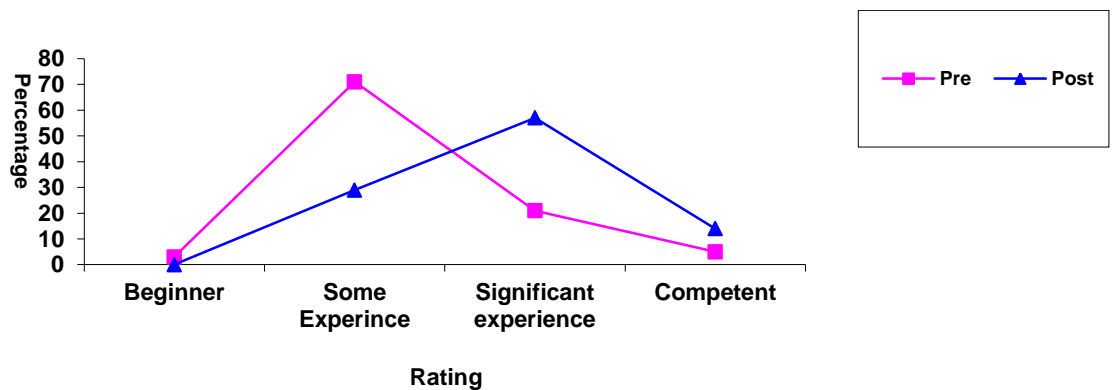
Overall

Certainly, the impression given from manager’s specific comments is that the programme has enhanced them and their ability to do their job in one or more areas. This is true both when considering responses from middle and senior managers.

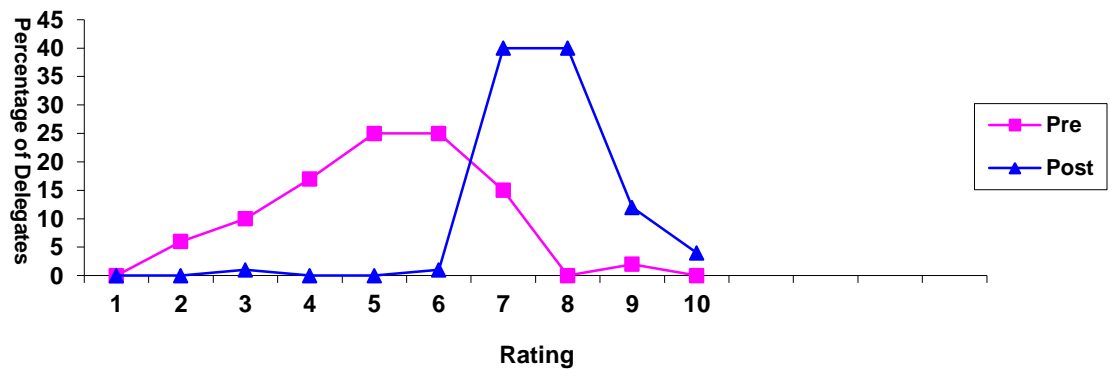
There was also excellent feedback given by both response groups on the effectiveness of the tutors. This, combined with positive feedback on the venue, was clearly conducive to a good learning environment. There were a couple of comments highlighting certain issues with the catering and some delegates felt the programme was too intense. However, on the whole feedback was once again extremely positive. Participants felt that their improved management skills would lead to improved organisational performance and hence better patient care. Particular skills mentioned were:

- People management, motivation, appraisals and team development
- Time management
- Influencing
- Implementing change/new ways of working
- Leadership
- Communication.

All cohorts saw an improvement of their perception of competence in relation to the content of the programme i.e. the percentage of those rating themselves as beginner or with some experience went down and the significant experience and competent category scores went up after the programme.



Prior to the course, most people rated themselves between 3 and 6 in relation to the knowledge and skill areas associated with the aims of the programme. After the course, this rose significantly with most participants rating themselves 7 or above.



Many participants also stated that cascading their new found knowledge and skills after the programme to their team and other managers would have an impact on the organisation and care provided.

“One of the most informative and professionally delivered courses I have taken part in”

“Excellent tutors and actors, very enjoyable course”

Feedback from the trainers

Feedback from the trainers was gained from regular Steering Board Meetings, which were also attended by members of the panel who selected the providers. The trainers provided information on their observations of the modules (for example the group dynamics), feedback given to them and details of actions that participants took in between modules to demonstrate their learning and changed behaviours.

Appendix 8

Evidence of Public Impact of Improvement Partnership for Ambulance Services

This was the first national leadership development programme for ambulance services in the UK and the first national support programme for ambulance services with a particular emphasis on challenged organisations.

- A Strategic Review of Ambulance Services was instigated as a result of the findings of IPAS
- endorsement by the ambulance profession was demonstrated by invitation to be part of the reference group for the Strategic Review of Ambulance Services by the Dept. of Health
- the IPAS work was referenced in the Dept. of Health Emergency Care Bulletins and the ambulance journals and Health Service Journal
- a series of national events were delivered and attended by staff from every one of the 32 ambulance services and their senior leaders
- I sponsored local Leadership Programmes through a Leadership Award for Ambulance Trusts
- for the first time the Health Service Journal Management Awards for the Emergency and Unscheduled Care Category included applications from ambulance services
- a series of publications resulted: (authored and or edited by me); see **Appendix 3/4/5/6.**

Description of Statistical Process Control

To quote the description on the NHS Institute for Innovation and Improvement website (http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/statistical_process_control.html)

'If you want a more efficient system, you need to reduce the variation. Common causes and special causes of variation indicate the need for two different types of improvement which can help you achieve this. If controlled variation (common cause) is displayed in the SPC chart, the process is stable and predictable, which means that the variation is inherent in the process.

If you want to improve the process, you will have to change the whole system. If uncontrolled variation (special cause) is displayed in the SPC chart, the process is unstable and unpredictable. Variation may be caused by factors outside the process. In this case, you need to identify these sources and resolve them, rather than change the system itself. There are three issues that you should be aware of when using SPC charts to improve a process:

- you should not react to special cause variation by changing the process, as it may not be the system at fault
- you should not ignore special cause variation by assuming that it's part of the process. It is usually caused by outside factors which you need to understand in order to reduce them
- you should ensure that the chart is not comparing more than one process and displaying false signals
- an example of this would be data covering two hospital sites, or two procedures that are very different.

SPC is a tool that will help you understand the scale of any problem (the degree of variation) and identify possible causes when used with other investigative tools e.g. process mapping, spaghetti diagram. You are then able to measure the impact of any improvement: does it cause more variation - bad or less variation - good?'

Appendix 10

Extract from the DH letter Director General Access, Margaret Edwards 23

December 2005

Within this it is clear that measurement of patient pathway from referral to start of treatment is crucial. Ultimately, this will be enabled by a more strategic IT solution but in the interim, a more tactical solution is needed. To this end, we want to work with a number of local health economies to support them developing simple and practical measurement systems to capture and record referral to treatment (RTT) times....

The initial objective is for the NHS to develop short term tactical approaches by early April 2006 for basic referral-to-treatment measurement for medical and surgical pathways using existing PAS systems. This will require the ability to record additional key decision points essential to the monitoring of 18 weeks regarding 'clock start and stop' points. This is summarised in the following table.

New Data Points	Already Existing
<ul style="list-style-type: none">• Decision to Treat (DTT)• Decision Not to Treat (DN TT)• Decision to commence period of watchful waiting (DCWW)• Treatment commencement date (non-surgical)	<ul style="list-style-type: none">• Referral date• Treatment date (surgical)
Clock Start	Clock stop
<ul style="list-style-type: none">• Referral date• Decision to Treat (clock re-start)	<ul style="list-style-type: none">• Decision Not to Treat (DN TT)• Decision to commence period of watchful waiting (DCWW)• Treatment commencement date (surgical)• Treatment commencement date (non-surgical)

Computing the control limits (Juran and Godfrey 1999)

Control limits for individual data, also called the X chart, are the centre line ± 3 times standard deviation, or $\mu \pm 3\sigma$

The centre line, the process average is estimated by the mean of the observations \bar{X} .

The process standard deviation is estimated by a calculation based on the average moving range. The moving range R is the absolute difference between the largest and smallest of two successive observations.

$$UCL_x = \bar{X} + 2.66\bar{R}$$

$$UCL_y = \bar{X} - 2.66\bar{R}$$

The number 2.66 is a constant based on a common rule of using moving ranges of size 2 (See Juran and Godfrey 1999).

Description of the No Delays Achiever & Screen Shots which Illustrate the Website

The No Delays Achiever provided the following:

- products aimed at operational managers, to make their life easier
- supported a series of publications translating theory into practice with real case studies
- a web-based product integrating Trusts' own data to the appropriate service tool / intervention
- a 'one stop shop' for service improvement and organisations development tools selected by their impact on patient access
- customised product, showing their own data
- no input from IT departments or analysts needed
- it was free
- they can see other organisations data
- they can drill down to consultant and GP level data.

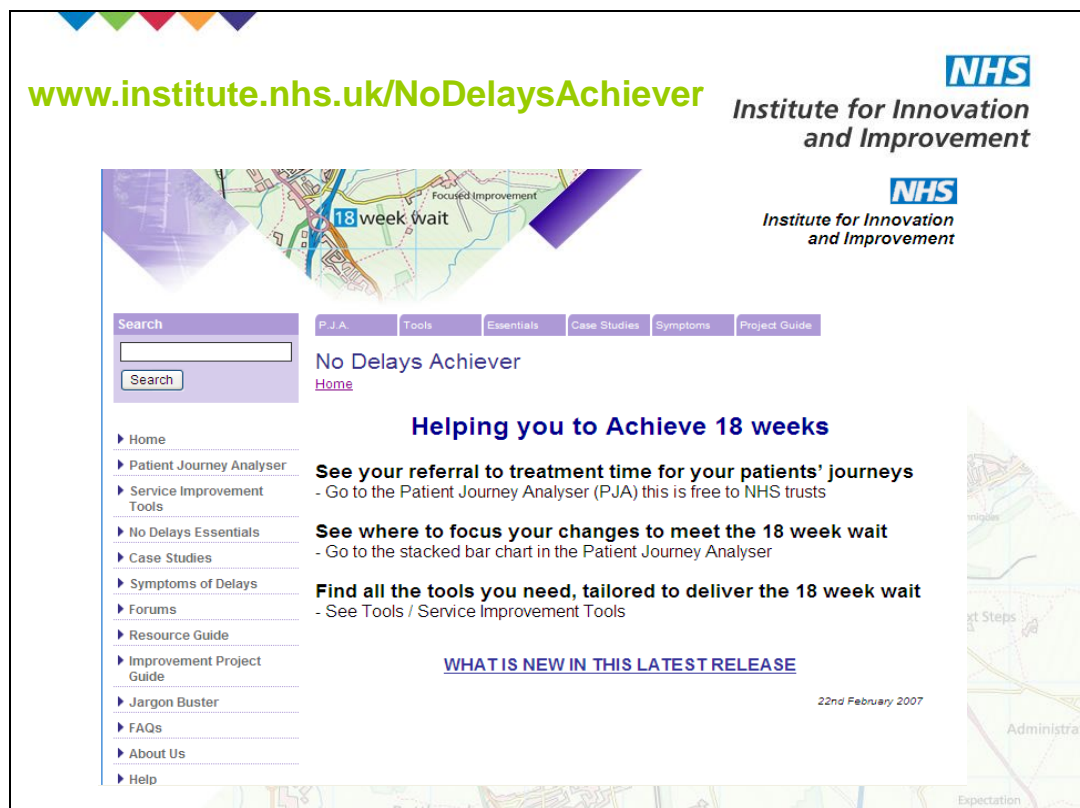
Some of the features of the tool included:

- being online, which enabled easy and instant access to information and an easy route to sharing knowledge about retrospective waiting times;
- use of data available from national returns, therefore providing a measure of referral to treatment time that did not require additional analytical support;
- provided NHS hospital Trusts with an opportunity to upload their own data and share via the web;
- analysis of the data for service improvement, with a particular focus on displaying variation and helping to focus on the Pareto

principle, that a relatively small number of processes will account for a majority of the problems (Juran and Godfrey 1999);

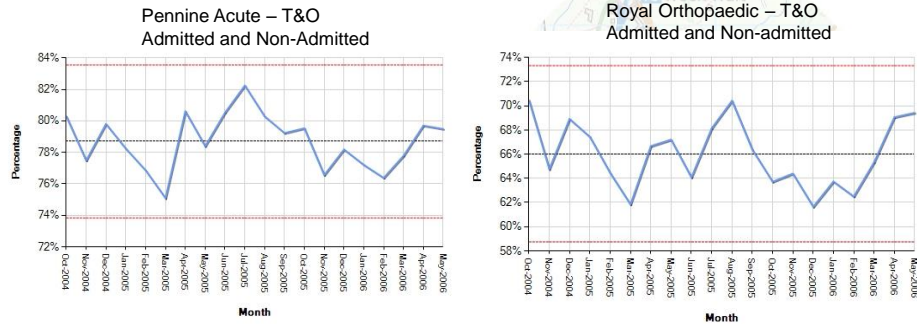
- supportive interpretation of these analyses and suggested next steps (which service improvement tools to use) based on this interpretation to support decision making;
- a range of service improvement tools and techniques that focus on developing a greater understanding of processes and systems, providing know-how about systems thinking and the human dimensions of change; and
- supported examples of practice and project management guidance.

Screen Shots to illustrate the website No Delays Achiever: it was turned off in 2009.



Customised tool – it's Trust's own data

- Here are data from 2 trusts showing how well they are achieving on the 18 week pathway, for their T&O patients to date



This offers reports from multiple perspectives and timescales Provider, Commissioner, SHA & National

Home

Patient Journey Analyser

Profile

Change Password

Logout

Service Improvement Tools

No Delays Essentials

Case Studies

Symptoms of Delays

Forums

Resource Guide

Improvement Project Guide

Jargon Buster

FAQs

About Us

Help

Text Only

Trust Level Selection

Home > P.J.A. > Trust Level Reports

Please select the desired criteria:

You can select a provider or commissioner. If you select both a provider and a commissioner this means you will analyse data for one hospital for services commissioned by one PCT. You can also select a Strategic Health Authority. To view England as a whole – leave all the options blank. To learn how to view your organisation's consultant or GP names (rather than codes) [click here](#).

1. Select Organisation

Provider:

Any/All

(Showing all Providers)

Commissioner:

Any/All

(Showing all Commissioners)

Strategic Health Authority:

Any/All

(Showing all Strategic Health Authorities)

2. Select Patient Type

Patient Type:

Elective (Type I) (5725751 journeys)

All Patient Types with Data

3. Select Month

Data is available for the following months:

October 2006 (158775 journeys)

Select Month

Create Report

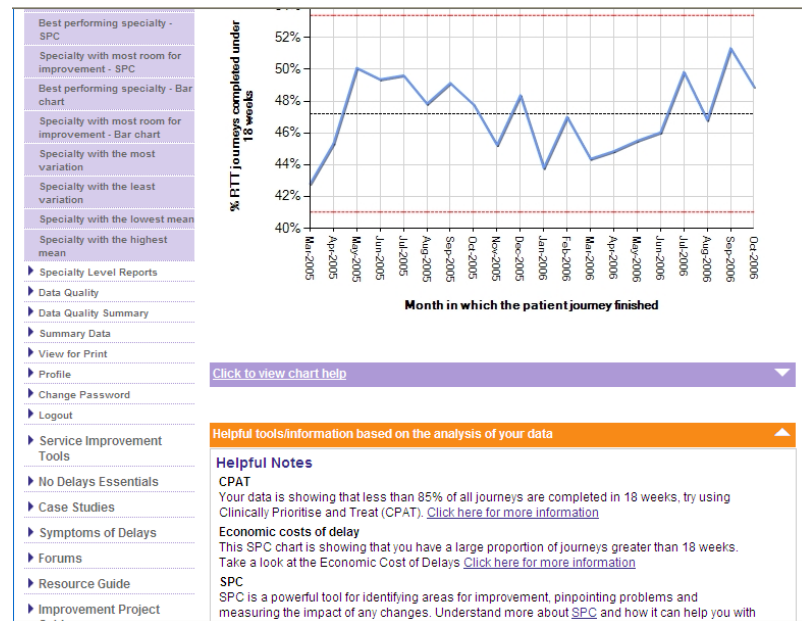
Compare this data*

Clear Current Selection

*Using this feature will allow any two organisations to be compared to each other. To check to see who

150

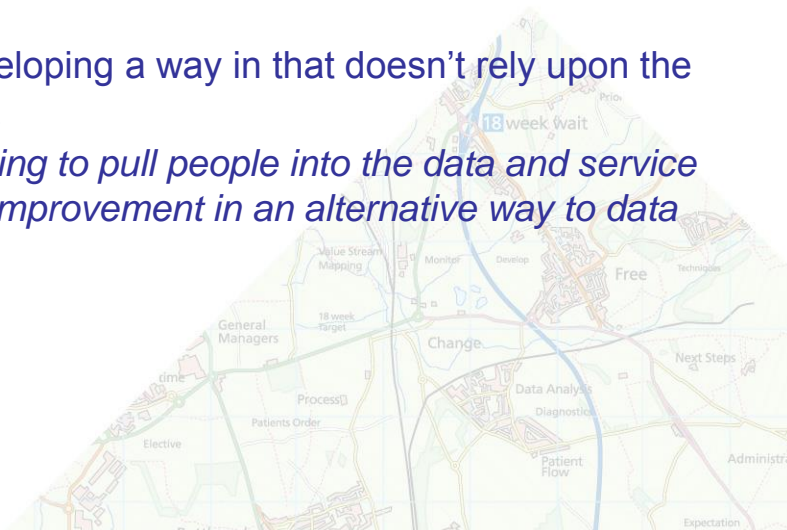
We link your data to service improvement tools



We are developing a unique approach – 'Symptoms'

- Developing a way in that doesn't rely upon the data

Aiming to pull people into the data and service improvement in an alternative way to data

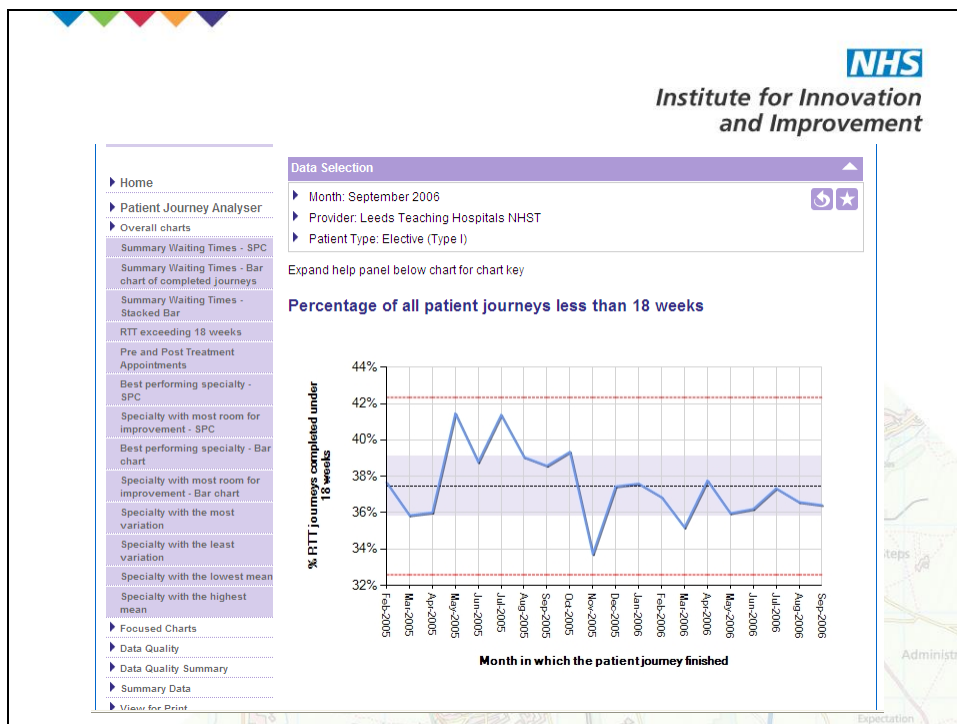


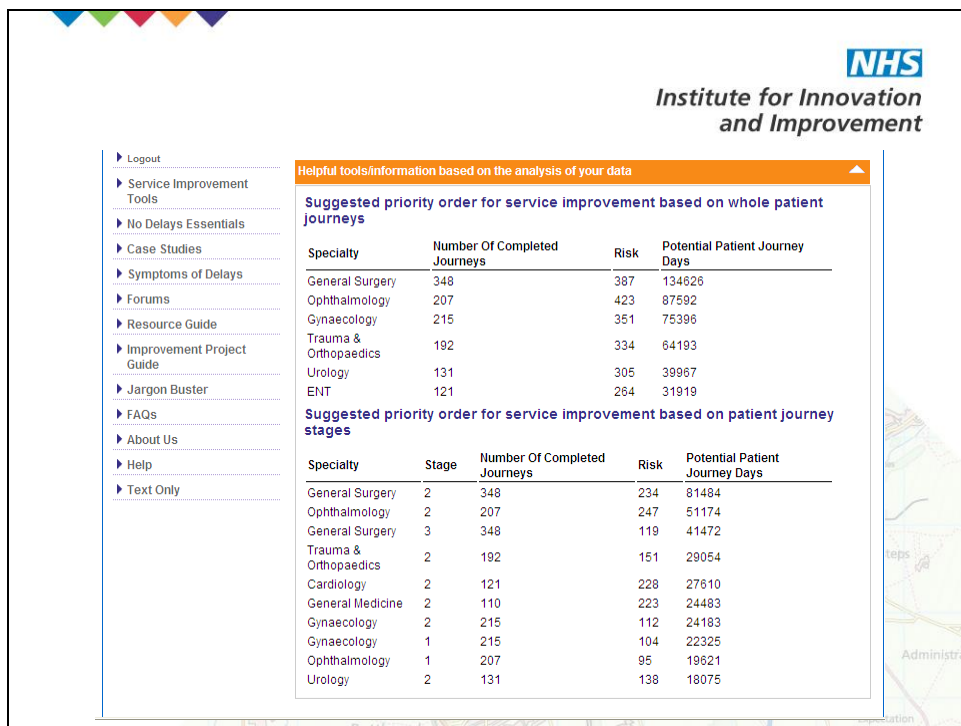
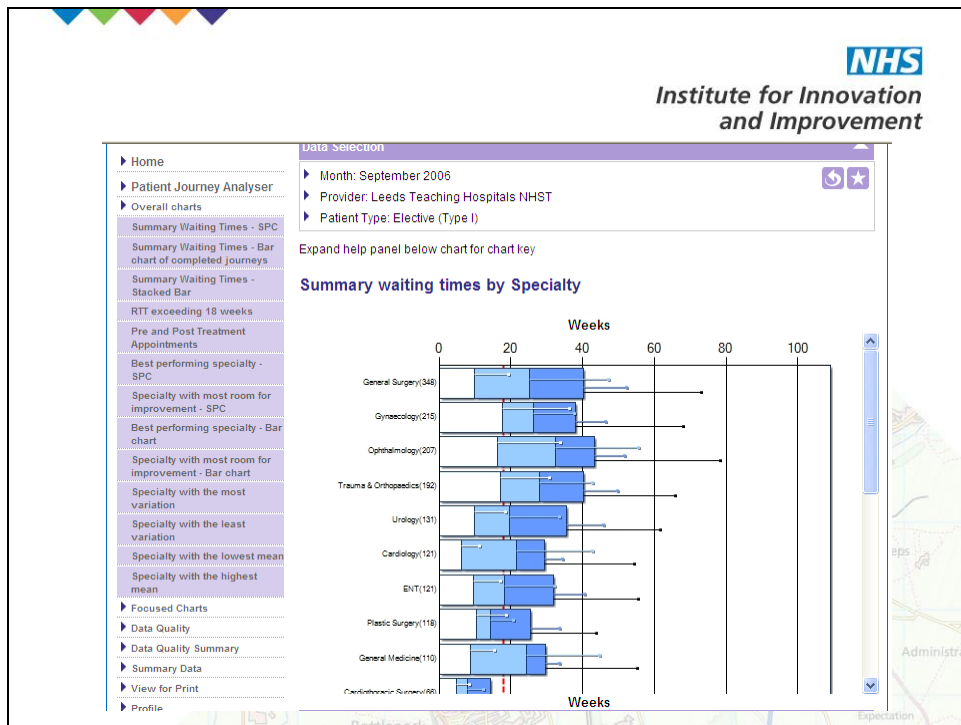
The 'No Delays Achiever' A Web Based Integrated Service Improvement Product

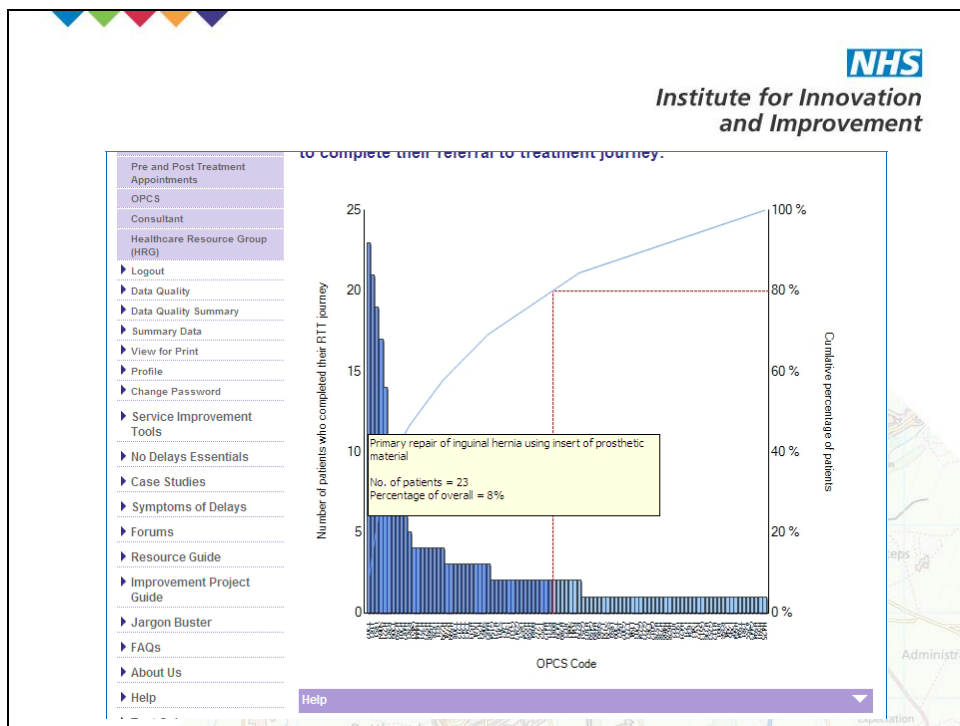
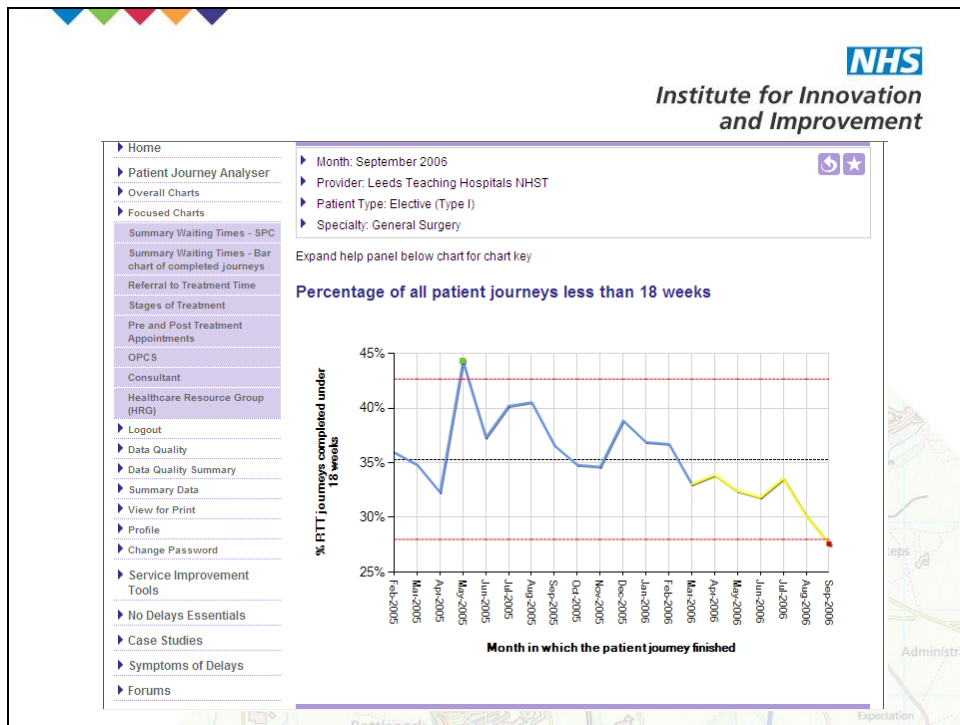
NHS
Institute for Innovation
and Improvement


7 things that make this product unique

1. Customised tool – it's Trusts' own data
2. We upload all the data (no need for your information teams to get involved)
3. The data covers the whole of the patients journey RTT
4. The PJA identifies where to prioritise effort
5. The PJA automatically links interpretation of your data with relevant service improvement tools
6. Service improvement tools tailored for 18 week wait
7. We are developing a unique approach – 'symptoms of delays'









**Institute for Innovation
and Improvement**

- Healthcare Resource Group (HRG)
- ▶ Logout
- ▶ Data Quality
- ▶ Data Quality Summary
- ▶ Summary Data
- ▶ View for Print
- ▶ Profile
- ▶ Change Password
- ▶ Service Improvement Tools
- ▶ No Delays Essentials
- ▶ Case Studies
- ▶ Symptoms of Delays
- ▶ Forums
- ▶ Resource Guide
- ▶ Improvement Project Guide
- ▶ Jargon Buster
- ▶ FAQs
- ▶ About Us
- ▶ Help

Other specified other operations on bowel (H528)

Other specified other operations on perianal region (H558)

Other specified other operations on rectum (H468)

Other specified other operations on varicose vein of leg (L878)

Other specified primary repair of inguinal hernia (T208)

Pancreaticoduodenectomy and resection of antrum of stomach (J562)

Partial excision of breast nec (B282)

Partitioning of stomach nec (G302)

Peranal excision of lesion of rectum (H412)

Percutaneous biopsy of lesion of breast (B321)

Percutaneous transluminal angioplasty of femoral artery (L631)

Primary repair of incisional hernia using insert of prosthetic material (T252)

Primary repair of inguinal hernia using insert of prosthetic material (T202)

Primary repair of inguinal hernia using sutures (T203)

Repair of diaphragmatic hernia using abdominal approach nec (G234)

Repair of oesophageal hiatus using abdominal approach (G233)

Repair of recurrent incisional hernia using insert of prosthetic material (T262)

Repair of recurrent inguinal hernia using insert of prosthetic material (T212)

Repair of umbilical hernia using insert of prosthetic material (T242)

Repair of umbilical hernia using sutures (T243)

Repair of ventral hernia using insert of prosthetic material (T272)

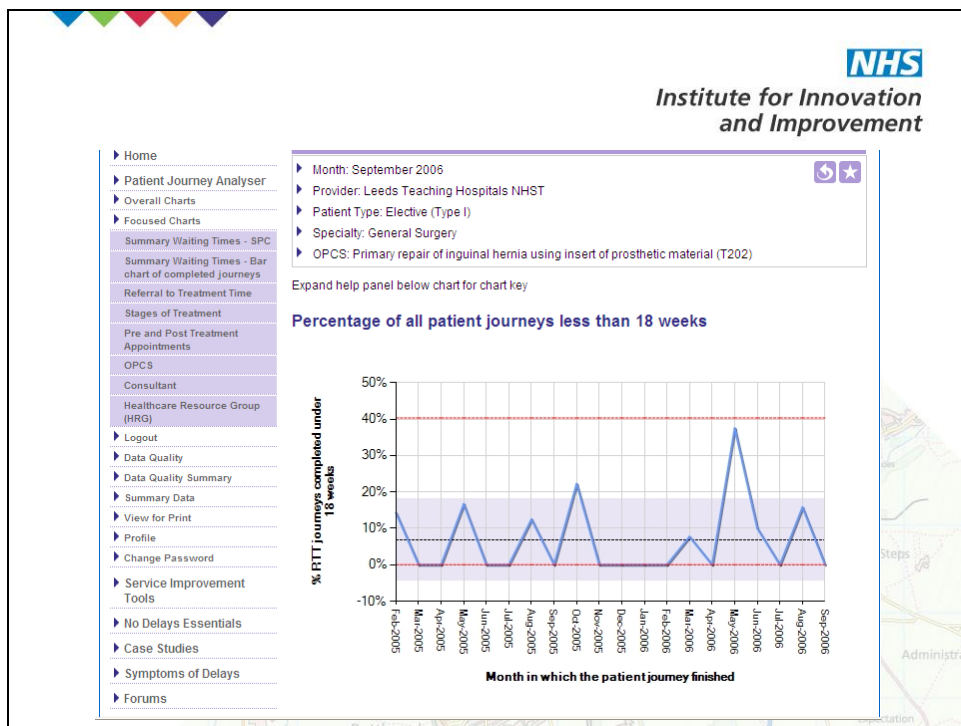
filtered by | Specialty: General Surgery | OPCS: Primary repair of inguinal hernia using insert of prosthetic material (T202)

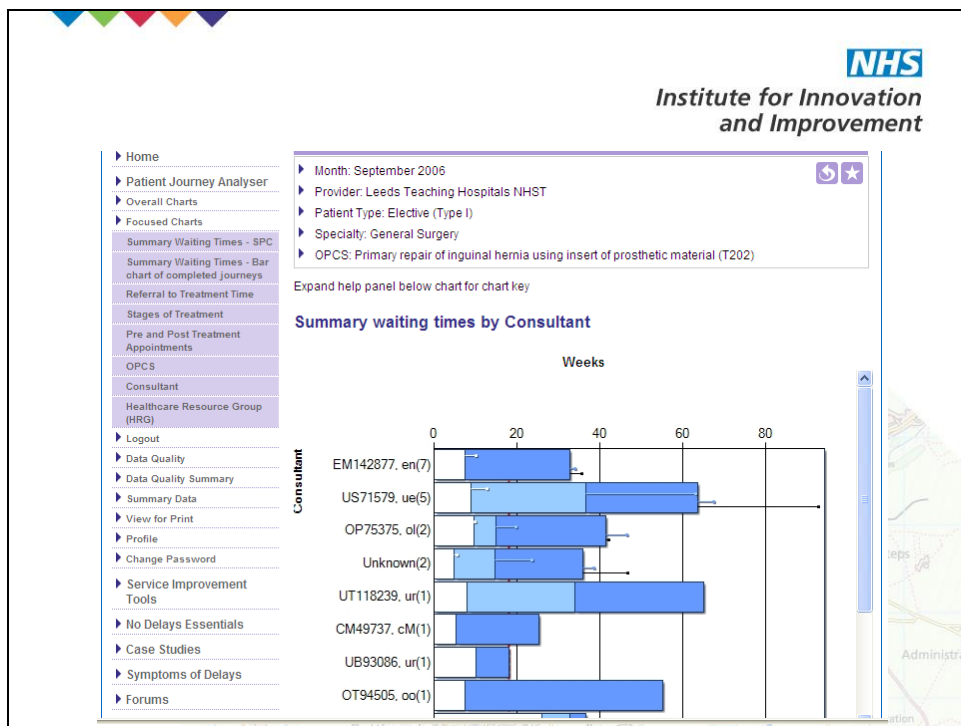
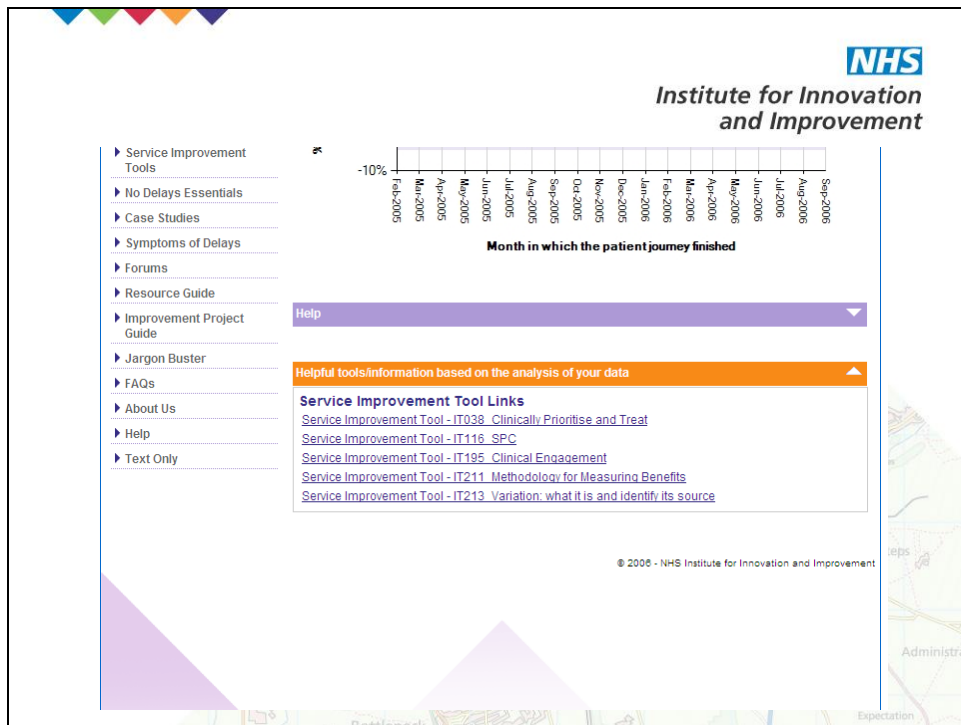
GP Practice:

All

Continue

Clear Selection





Appendix 13

Evidence of Public impact of the No Delays Programme and the 'No Delays Achiever' website

'This is unbelievably clever'

Imperial College

"This methodology will give a good understanding of what can be measured."

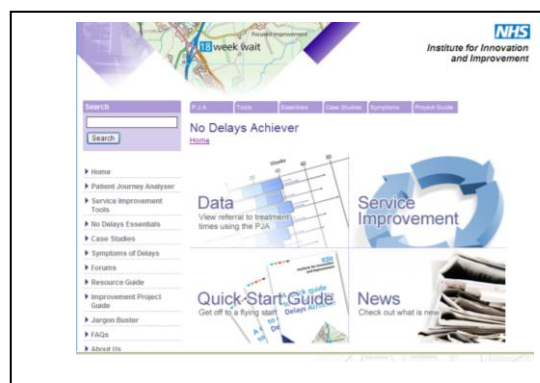
Information Manager at the Luton & Dunstable Hospital

"Our Trusts have not yet got round to such a comparison, your No Delays Achiever allows you to do it easily and great to have at specialty level."

Head of Healthcare Improvement, Bedfordshire & Hertfordshire SHA

Through the development of a range of resources I contributed to the challenging target of delivering the referral to treatment time target of 18 weeks. (No Delays Achiever website, associated publications, national workshops and a helpline)

The No Delays Achiever site received in excess of 20,000 hits per month. Every NHS organisation had registered users. 'No Delays Achiever' had developed into an international resource with more than 20 countries accessing the No Delays Achiever – including 2,000 hits per month from America.



No Delays Achiever enabled analysis of a Trust's referral to treatment (RTT) times, linking data to an improvement tool. Data was entered every month and Trusts could compare their RTT with any other NHS organisation. It allowed statistical process control; it charts referral to treatment times and drills down to speciality level reports even down to consultant.

The No Delays Achiever incorporated:

- The Patient Journey Analyser –Tools – more than 100 service improvement tools, tailored to help 18-week delivery
- Essentials – six key areas that can really make a difference to achieving the 18-week wait
- Improving project guide. An easy to understand seven step guide providing assistance in small or large-scale projects
- Case studies – learning from others, real examples of where the NHS has made improvements towards a delay-free system
- The facility for Trusts to upload their own data so they had access to free analytical tool for 18 weeks and share their own data with their colleagues across the net
- A commissioner module allowed commissioners to compare multiple provider 'referral to treatment' data.
- A module for Practice Based Commissioners where they can establish their own clusters and review the data from the Trusts they commissioned from.

As commissioners of healthcare had in impact on the ability of providers of healthcare to deliver the 18-week target, I designed and delivered a unique publication. **Commissioning for Patient Pathways** was launched in September 2007. The first guidance of its kind supporting commissioners on Commissioning for Patient Pathways for sustaining 18 week pathways and also having a broader application for commissioning generally.

Further the No Delays programme supported commissioners through:

- Running more than 125 workshops per year for NHS staff
- Establishing a community of practice for NHS Commissioners supporting 30 PCTs in learning how to commission patient pathways

- Developing two PCT and eight acute Trusts as Ambassador sites for the No Delays Achiever, with project manager support.

Having just reviewed the No Delays website I have to say that the content is astounding and for the first time offers a comprehensive support site for all aspects of Commissioning.

Paul Mugford

Practice Manager

Hillview Family Practice, Hartcliffe Health Centre

Hareclive Road, BRISTOL BS13 0JP

The Commissioning for Patients Pathways work was subsequently edited to remove the 18-week perspective and is still used as a guide to commissioning today in 2013. In 2011 it was viewed and downloaded 10,198 times. It has now been removed from the website as it was being misappropriated by independent consultants.

Although the No Delays Achiever was turned off (2009) when the NHS target of 'Referral to Treatment times' was achieved, the library of service improvement tools was edited to remove the 18-week bias and is now available on the NHS Institute for Innovation and improvement:
www.institute.nhs.uk/qualitytools.

Under the No Delays programme I published two sets of national guidance based on good practice for the Dept. of Health:

- [Commissioning Patient Pathways Guide](#); accelerating the achievement of world class commissioning
- [Seven Ways for No Delays](#).

Professionally it gave me an international reputation, I was asked to speak at conferences and advise Health Ministers (Canada) and health providers

(Australia). We had regular users of the No Delays Achiever website in 36 countries.

Some of the spread is unknown. For example in December 2011, my ex-CEO Prof Bernard Crump was working in Singapore and wanted me to send him a presentation based on our publication 'Seven Ways to No Delays' as they had heard about it and wanted to learn more.

Scotland NHS bought these resources (The No Delays Achiever) to deliver their own waiting time targets.

Examples of endorsement by users:

'Julia,

Thank you for the fantastic Christmas present that arrived today.

The No Delays Achiever and pack looks superb and my colleagues at Whipps Cross are already using it. Needless to say we have found it is useful for much more than the no delays agenda and is assisting us with our turnaround programme, capacity planning, annual planning and budget setting.

Best wishes to you and well done on a great programme'

Tony Ranzetta 12/01/2007

'Julia,

Congrats again. I'm consistently finding the latest version of the No Delays Achiever is even more user friendly than the earlier one. It really is a superb product for the NHS supporting them in delivering the 18 week target.

Kind regards,'

David Adler East of England Strategic
Health Authority 12 March 2007

Question submitted from the No Delays Achiever website:

'Question: not a question but a comment - this is excellent in all respects - a great distillation of all we know about improvement and eliminating waits - well done . A great medium for getting the message across; Well-done Julia'

Michael Scott Audit Commission 2007

And praise for my work came from unexpected sources, the President of a Consulting Firm, Dragonfire Systems Ltd in British Columbia; Canada emailed the No Delays Team.

He wrote: "My current subject is Continuous Improvement, Innovation and Change. My background is varied (from insurance to law enforcement) and I have no connection to health care whatsoever. However, in poking around the Internet, I stumbled into your website (No Delays Achiever). I was first interested and then delighted.

*Good for you. The overall feeling is upbeat and positive. I sincerely hope that the No Delays Team and the NHSI in general is very successful because your goals are admirable and your overall energy uplifted even me. The real world can be discouraging at times and it is clear that while you understand how difficult challenges like the No Delay Programme must be, you plan to construct new solutions to make it happen anyway. Good for you. Please be aware that one small component of the world at large is on your side and rooting for you."*2007

'I must congratulate you on the content of the No Delays Achiever and the ease with which the site is navigated. I find it most helpful'

Jill Newman Wales NHS 26 Feb 2007

Publications

A series of publications (authored, or edited by me, some commissioned) some translating theory into practice and illustrated with real case studies.

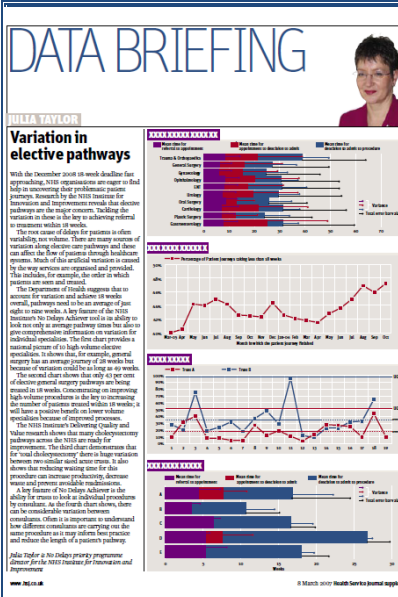


Some publications commissioned by me (see below):







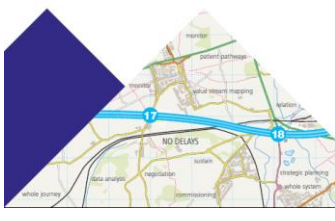




In March 2007 I commissioned a company to undertake a scoping study into the barriers and opportunities to promote effective commissioning for 18-week pathways. A literature review was one component of this scoping study and was published. The scoping study also involved:

- One-to-one and focus group interviews with key stakeholders, representatives of PCTs who are responsible for commissioning and/or achieving 18-week pathways, practice-based commissioners (PBCs) and commissioning leads in SHAs
- A web based review of guidance and tools on effective commissioning and achieving 18-week pathways.

Articles in UK healthcare publications; e.g. Health Services Journal (HSJ), Operations Management Journal, National Health Executive Journal, HSJ.

Illustrations of evidence

		
<p>Articles in the high profile Health Services Journal</p>	<p>Scotland buys the No Delays Achiever and I speak at their national conferences</p>	<p>Publication: Seven Ways to No Delays.</p>

<p> Institute for Innovation and Improvement</p> <p>Improving Patient Flow in the NHS Case studies on reducing delays</p> 	<p> Institute for Innovation and Improvement</p> <p>Executive summary Commissioning to achieve 18 week pathways January 2008</p> 	<p>Institute for Innovation and Improvement</p> <p>Levers for Effective Commissioning of 18 Week Pathways March 2008</p> 
<p>Improving Patient Flow in the NHS. Case Studies on reducing delays</p>	<p>Executive Summary: Commissioning to achieve 18-week pathways</p>	<p>Levers for Effective Commissioning of 18-week Pathways</p>
<p> Institute for Innovation and Improvement</p> <p>Literature review concerning effective commissioning to achieve 18 week pathways September 2007</p> 	<p> Institute for Innovation and Improvement</p> <p>Strategic Health Authorities' perspectives on effective commissioning: commissioning to achieve 18 week pathways November 2007</p> 	<p> Institute for Innovation and Improvement</p> <p>A quick guide to using the No Delays Achiever</p> 
<p>Commissioned; Literature review concerning effective commissioning to achieve 18-week pathways</p>	<p>Commissioned: Strategic Health Authorities' perspectives on effective commissioning: commissioning to achieve 18-week pathways</p>	<p>A quick guide to using the No Delays Achiever</p>

The following are just a few quotes I received in praise of *Commissioning for Patient Pathways—A practical guide for achieving and sustaining 18 weeks*.

“Not just for advanced users – it’s also a good beginners’ guide to commissioning.”

“A great new way of looking at commissioning” – Cancer Consultant

“This is what you do for world class commissioning for the next two years.” – Research consultancy

“I wish we had had this years ago.” Experienced PCT commissioner

“Really helpful – provides a good framework for commissioning” – PCT Commissioner

“Not just useful for 18 weeks but also for the whole of our commissioning work” – PCT Commissioner

“A great guide for whole system planning” – Acute Trust Commissioning Lead

“More than just a list of good practice” – really something related to pathways”

Appendix 14

Leadership Traits Necessary to be Able to Lead Large-scale Change

‘Academy for Large-scale Change’ (Oct 2008–March 2010). The programme identified a range of leadership traits necessary to be able to lead large-scale change as opposed to small scale change: (identified through semi-structured interviews with the participants).

Less of this		
Short term planning		Long term planning
Focus on execution of the plan		Focus on getting the best outcome
Designing the solution from within the organisation		Exploring opportunities for a wide range of others to influence
Expecting others to ask permission in advance		Expecting others to ask permission in advance
Using familiar approaches		Seeking new and novel approaches
Demanding perfect solutions		Working with emergent ideas and incomplete solutions
Talk to the same (NHS) colleagues		Engaging a wide network of different people from different orgs
Organisation focus – autonomy beats quality		System accountability – quality beats autonomy
I am a leader of my organisation		I am a leader working to improve the health care of our population
Telling people what to do and how to do it		Framing, engaging, listening, coaching

Waiting list targets (and milestones) announced since 1997–2007

Examples:

1. Cut inpatient waiting lists by 100,000 from March 1997 level,
End of 1997
2. No-one with suspected breast cancer to wait more than two weeks
for outpatient appointment following urgent GP referral,
April 2000
3. Numbers of outpatients waiting more than 13 weeks to be cut to
334,000, March 2000
4. No one to wait more than four weeks for treatment for testicular
cancer, children's cancers and leukaemia following urgent GP
referral, December 2001
5. No one to wait more than 4 weeks for treatment for breast cancer
following diagnosis, December 2001
6. No one with suspected cancer to wait more than two weeks for
their first outpatient appointment, for patients referred urgently,
December 2000
7. Reduce number of people waiting over 12 months, March 2002
8. No one to wait more than 15 months for inpatient treatment,
March 2002
9. No one to wait more than 12 months for inpatient treatment,
March 2003
10. No one to wait more than 9 months for inpatient treatment,
March 2004
11. No one to wait more than 6 months for inpatient treatment,
March 2005
12. No one to wait more than 3 months for inpatient treatment (and an
average wait of 1.5 months), End 2008
13. No one to wait more than 26 weeks for an outpatient appointment,
March 2002

14. Reduce the number of people waiting over 13 weeks, March 2002
15. No one to wait more than 13 weeks for an outpatient appointment, March 2005
16. Maintain the commitment to cut waiting lists by 100,000 from March 1997 level
17. All patients attending A&E to wait four hours or less, from arrival to admission, transfer or discharge, March 2004
18. No patients to wait no more than 24 hours for an appointment with a primary health care professional, and no more than 48 hours for an appointment with a GP, March 2004.

Appendix 16
iLinks Business Plan

See next page

iLinks Business Plan (Based on a 'lean A3 Summary' type approach)

Objective: Helping the Institute evolve in harmony with its NHS environment by understanding and anticipating customer needs and matching the Institutes response

Overarching iLinks Objectives

- Identify and develop ways of better aligning Institute offerings to customer needs for maximum patient benefit
- Identify and enable linkages between products or their elements, modifying as necessary to create overt added value portfolios/packages of support for the NHS. Aligning products to positive patient experiences.

On behalf of and with the Institute, we will work in the following areas;

Work with External stakeholders

- Identify the Internal NHS Institute channels for external customer engagement.
- Identify who is actively engaging with the NHS Institute and understand what they consider to be a world class service
- Positively influence how our brand is perceived in our immediate and wider market(s)
- Review what other competitors and collaborators are offering within the NHSI target market
- Develop flexible environments to support scoping of diagnostic tool requirements, gaining customer feedback and undertaking continuous testing and product prototyping.

Engage Internal stakeholders

- Work with users to build more effective communication channels to facilitate better linking of products and to enable collaborative product development between teams
- Being responsive in supporting Institute staff around product knowledge and the linkages

Analyse NHS Institute products

- Ensuring products are explicitly connected to each other where appropriate to maximise impact of products
- Ensure products are explicitly linked to needs identified by the NHS
- Ensure products are accessed via appropriate delivery vehicles that are easy to navigate
- Working to support systems and processes throughout product lifecycles

Continue to support No Delays

- To build on the spread and adoption work completed in the 2007-08 year, through a more targeted approach
- To use the No Delays Achiever as a pilot for iLinks
- To manage the legacy of the No Delays Achiever effectively, including commercialisation

Current situation

Product synergies are not used to develop packages of support, Duplication occurs

Concerns (edited)

Issue; Information

- Stakeholders do not actively engage and therefore data / information cannot be collected

Issue; Resource/capacity

- External and/or Internal stakeholders do not have sufficient time to fully input into the programme leading to solutions that do not fit the requirements
- Test sites are not able to fully test the solutions and therefore give an incomplete or incorrect impression of the tools
- Funding and capacity within teams may be insufficient to cover potential required modifications to existing products and services
- Since this programme is not externally facing there may be an expectation that capacity is diverted from this work to new priorities (such as the outcomes of the Darzi review)
- The team is at risk of further headcount reduction due to two secondments coming to an end and a third currently vacant

Issue; adoption and sustainability

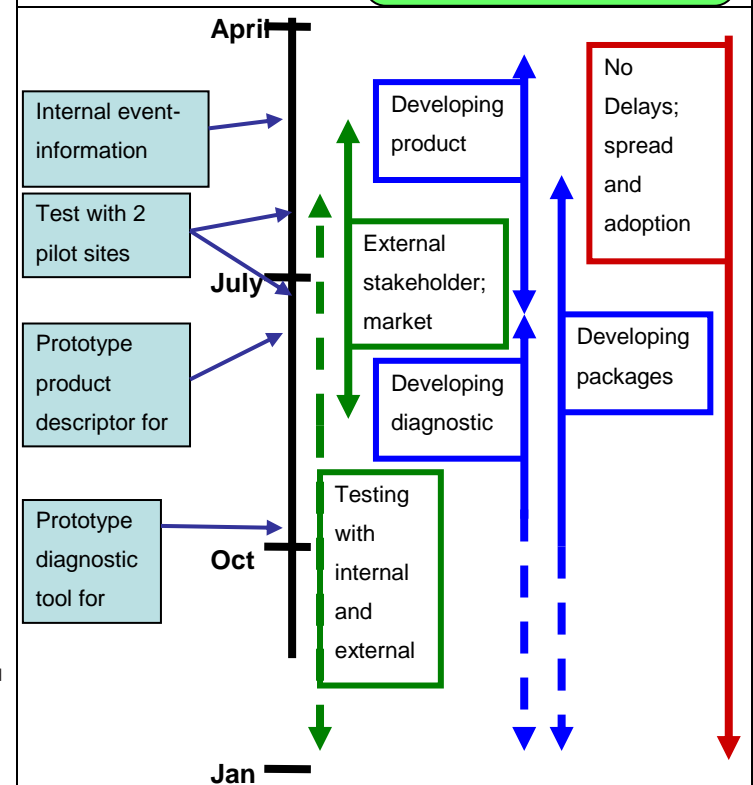
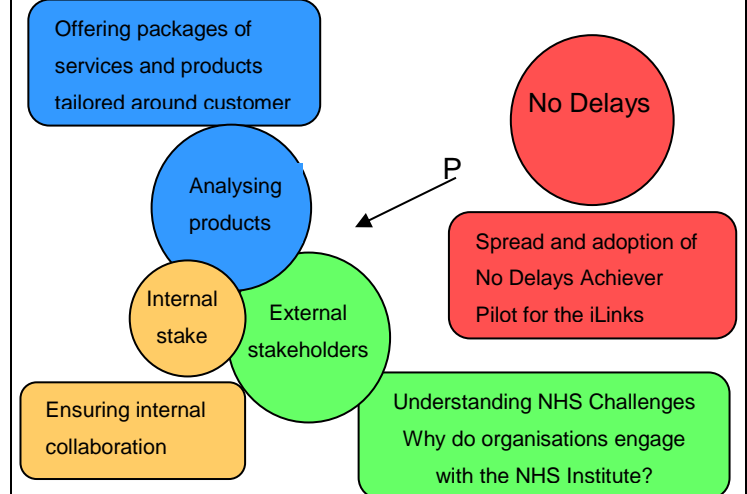
- The information gathered about the current NHS Institute products becomes a stagnant snapshot of the current position of the NHS Institute, unless the processes are established by the Programme office and the Transition group
- The Institute may become dependent on the iLinks team to carry out the function of maintaining the linkages between products and services
- Potential new delivery vehicle for NHS Institute products and services are not universally adopted by teams,

Issue; Internal engagement

- NHS Institute team's affiliation with their own products may result in resistance to potential modification of products, which may be deemed necessary to create more robust linkages between products
- Multiple internal product mapping exercises that are currently taking place across the NHS Institute, for slightly different purposes, may result in duplication of effort and reduced internal engagement
- The NHS Institute does not act on what the information the research and testing identifies, leading to incomplete adoption of solutions and a potentially complex environment for the external customer

The team will be perceived as failing if expectations/scope are not managed (e.g. there may be expectations that we will act as a sales force; take on events and exhibitions; solve all of the perceived communication issues between teams at the NHS Institute)

Proposal



Application Process for iLinks Co-Production Sites

NB this application did not succeed

<p>Name of Trust: [REDACTED]</p> <p>Please describe why you would like to become an iLinks test site and how you believe it will benefit your organisation.</p> <p>Following a conversation with [REDACTED], [REDACTED] understands the iLinks Test site programme is about testing new models of service delivery for the NIII. The two models are specifically firstly around service transformation, learning and training and secondly about consultancy, and helping organisations to understand the processes to identify their challenges.</p> <p>[REDACTED] has an ambition to become the best hospital in the Country, and to become and remain the hospital of choice for all our local and other wider populations.</p> <p>All the corporate objectives for 2008/09 are associated with either Patient Experience, Patient Safety, Efficiency or Performance beyond Targets.</p> <p>Last year [REDACTED] launched our programme of improvement for the whole organisation, called Rapidly Improving Services For Everyone (RISE). This is an umbrella for a number of projects and initiatives, including the introduction of an Ideas Scheme, the development and integration of a core set of values for the hospital, a leadership development programme, that began with our clinical leaders, and finally the introduction of 'lean' as the chosen improvement methodology.</p> <p>Associated with the RISE programme is the need to ensure all our staff are trained in service transformation/improvement tools and techniques. We are considering how a package of learning can be introduced into the organisation that will enable all front line staff to improve services for both patients and staff alike. There is also a need to ensure we have more staff who can act as facilitators and leaders within their own areas of work, so that they are not reliant upon the service improvement team. As an organisation, we are keener to take part in the model to develop service transformation and training packages,</p>
--

but recognise the value of the consultancy model, and would be happy to work with both of the models.

The organisation is currently reviewing its strategy for the next 3 -5 years. One of the pieces of work is helping clinical and administrative teams identify where they have areas of weakness that will affect the organisation achieving its ambition. This process has been helped in part by the work undertaken within the organisation in 2007 by Simpler. Simpler were the consultancy group who worked within [REDACTED] to introduce 'lean'. They brought with them a process and model that is helpful in enabling teams to identify their own areas of concern, in a 'blame-free' environment. However what Simpler also had, was a language that was almost alien to the NHS. [REDACTED] has worked very hard to customise their process to ensure junior members of staff can understand what is required.

Please describe the structure in place in your organisation for delivering the aims of the test site.

The organisation has a devolved structure, with three Clinical Divisions, and one Administrative Division, being supported by four Corporate Directorates.

The Service Improvement Team (SIT) sits within the Business Development directorate.

The SIT are responsible for the introduction of lean, and any associated training.

Should [REDACTED] be successful in becoming a test site, the aims and objectives will be agreed with the NIHL. The iLinks team will work specifically with the Service Improvement Team.

The SIT are key stakeholders at the Corporate Service Improvement and Innovation Committee (CSIIC). This monthly meeting reviews all the service improvement work being undertaken across the organisation. It has representation from all the Divisions, including medical staff, and has amongst its membership the Chief Executive, and the Chief Finance Officer. The Chief of Operational Services is the Chair of the meeting.

There is also an organisational wide Corporate Education, Training and Development Committee (CETDC) that is chaired by the Chief Executive and includes in its membership the Medical Director, Director of Human Resources and the Director of Service Improvement.

Both CSIIC and CETDC report to the Hospital Management Board, which is also a monthly meeting to which all the Chiefs of Divisions and Corporate Directors attend. Any deviation

from plan with the pilot site could be reported to the Board if necessary.

The organisation is currently developing a benefits management and tracking tool that will ensure delivery of the project aims. These are also expected to be submitted to CSIIIC for note and approval.

Please describe how you will ensure top level management endorsement for this initiative.

This pilot will be led by the Director of Service Improvement. It will be sponsored by the Chief of Business Development and will report to several monthly corporate committees that include in their member other senior managers from the organisation, including the Chief Executive.

The Chief Executive fully supports this pilot.

Please describe how you will ensure that use of the NHS Institute for Innovation and Improvement products are identified, spread and sustained in your organisation beyond the project life span.

The Director of Service Improvement has as part of her portfolio the requirement to ensure staff are trained in service improvement tools and techniques to enable them to provide services that are over and above the expectation of patients. Any assistance in the form of external products and tools are invaluable in achieving that objective. The DSI works across the organisation, not just in clinical areas. This in turn will ensure that where a product meets the needs of a specific team they will be used.

Just by taking part in the pilot will ensure that any products or models that are developed will be more firmly understood by the SI team within the hospital and will spread and sustained as a consequence.

The organisation is also working with the SHA and Sheffield Hallam University at improving service improvement training for pre-registered clinical staff. Any products or models developed will clearly become an integral part of that training.

The Chief Executive sponsor for this project will be:

Name	
Job title	
Email	
Telephone no.	

The Director level sponsor for this project will be:

Name	
Job title	
Email	
Telephone no.	

The lead for this project in the Trust will be:

Name	
Job title	
Email	
Telephone no.	

By taking part in this programme the organisation will be agreeing to:

- Commitment and sign up from the Chief Executive and senior team to support the iLinks team and NHSI products.
- Nominated staff attending a workshop run by The NHS Institute for Innovation and Improvement at the commencement of the project.
- To accept Project Management support for three days per week over a 6 month period (this is fully funded by The NHSI).
- To develop in conjunction with the NHSI a project plan with clear objectives outcomes and metrics in conjunction with the allocated Project Manager.
- Commitment to identify in conjunction with the Project Manager, a number of products which the organisation will link to form packages.
- To report regularly to the NHS Institute for Innovation and Improvement and on progress against the project plan.
- To meet the Client Manager on a monthly basis to discuss the rollout of the initiative.

- To positively promote the NHSI and relevant products.
- To attend forums facilitated by the NHSI to discuss progress, troubleshoot and learn and share.
- To ensure use of NHSI products are spread and sustained beyond the project lifespan.
- To tell your 'story' of being an iLinks test site through various media routes (website, workshops, case studies etc.).
- Agree to undertake baseline measurement research on the use of NHSI products, both pre and post iLinks support.

The Range Options of Support Tested with a Co-production Site

I offered the co-production site a range of options and asked *what would add most value from the NHSI?*

Option 1: Matched the NHSI products to their identified challenges without any further diagnostics, just based on the list they had shared. This idea could have been designed as an on-line support toolkit.

Mapped out in advance I discussed the range of products that could contribute to addressing their challenges.

NHSI Tools to support products	Theatre Efficiency	Capacity Planning	Cancelled Operations	Workforce Productivity
Productive Series (based on Lean principles)				
Productive Theatre (Sep 08)	X	X	X	
Productive Ward		X		X
Productive Leader (June 08)				X
No Delays Achiever Service Improvement Tools				
Cancelled Operations including "Theatre Programme Guide"	X	X	X	X
Pre-operative Assessment	X		X	X
Operating Theatre Capacity Model	X	X		X
Process Templates	X	X		X
Reducing DNAs	X		X	X
Demand and Capacity		X		X

Safer Care				
Leaders Improve Patient Safety programme	X			X
Generic Tools				
Going Lean in the NHS (publication)	X	X	X	X
Seven Ways for No Delays (publication)	X	X	X	X
Improvement Leaders Guide (publication)	X	X	X	X
Better care better value indicators (on line data base)			X	X

It can be seen that it was the No Delays Achiever Service Improvement Tools and the generic publications which offered the most support to addressing their challenges. This Trust board clearly articulated that sign posting to a range of products and publications was useful but did not meet their needs. This was a typical response for all our six pilot sites they stated they needed the skills to use them: ‘reading a book on how to ride a bicycle does not mean you can actually ride one,’ a director stated.

Option 2: Recommend a flow of products (the original idea for iLinks, i.e. bundling/integration of products)

I demonstrated the following example: Flow of tools/products around ‘Cancelled Operations’ which they had identified as a challenge.

1. Root Cause Analysis
 - Look at the data first
(Look at No Delays Achiever and the Better Care Better Value Indicators explorer tool)
 - ‘5 Whys’ (an improvement approach described on the No Delays Achiever)
2. See the No Delays Achiever for:
 - a. Cancelled Operations Service Improvement tool
 - b. Planning and Management
 - NDA Improvement Guide
 - Stakeholder analysis
 - Clinical engagement
 - Glenday Sieve
 - c. Diagnose and Analyse
 - Cancelled Operations Diagnostic tool
 - d. Improve Theatre Operating Performance
 - Pre-op assessments
 - Process templates
 - e. Scheduling
 - Process Templates
 - Process Mapping
 - Identifying the essential resources
 - Analysing Constraints (Theory of Constraints)
 - Improvement Leaders Guide; matching capacity and demand.

Again the pilot Trusts were unanimous in stating that the sign posting of a process to go through offered some great value, but they would remain reliant on having access to people with these skills. They wanted to be able to self-diagnose and apply the relevant tools themselves.

Option 3 Conduct a diagnostic to help identify and define your key challenges/ areas for improvement, to be followed option 1 and/or 2. Uniquely there would be a charge for this option, unlike options 1 and 2 which could be automated within a web-based resource.

I used their challenge of ‘Cancelled Operations’ as an example. For this Trust there was a radical decline in their performance which coincided but was unrelated to winning an award for their performance.

Using Department of Health publically available data their challenge was clearly highlighted:

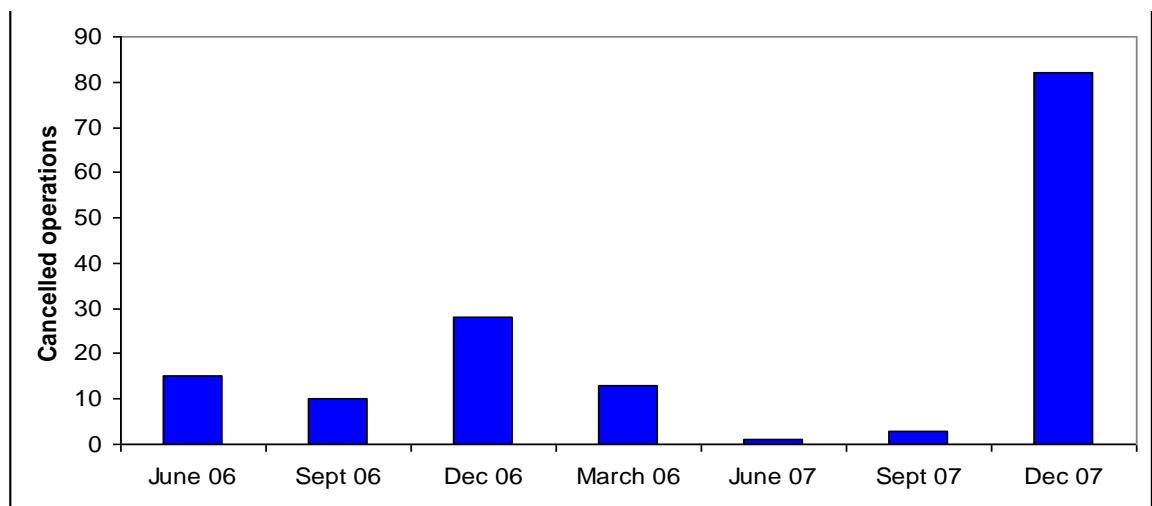


Figure 1: QMCO returns for this Trust. (The Quarterly Monitoring Cancelled Operations Data Set (QMCO) provides essential information for monitoring key targets and standards in the Cancelled Operations Guarantee)

Through my learning gained in supporting Trusts in achieving the 18-week access target for patients I suspected that the focus of this Trust on the 18-weeks target was affecting their ability to manage their non-electives, thus increasing cancelled operations. This transpired to be the case, but there was a need to explore further data so I asked if they reviewed this data:

- cancelled ops – do you collect other data on cancelled ops; e.g. clinical, patient initiated, before day of surgery?
- cancelled lists and reasons
- percentage of patients having pre-operative assessments (timing of pre-op, quality)
- theatre efficiency; first patient knife-to-skin to last patient into recovery times (start time, finish time and overall theatre utilisation)
- theatre efficiency; each patient knife-to-skin to recovery—un-utilised time within list.

At the time this Trust did not use the data described above and reviewing would provide a more balanced insight into their challenges. I thought the Trust needed to take a more holistic approach to achieving the 18-weeks target, thinking of the whole system. Not just focusing increased activity for elective care, but looking at eliminating waste in their processes (as illustrated by the bullet points above) and becoming more efficient. Key factors to consider were illustrated in our publication, *Seven Ways to No Delays* (Taylor, Shouls 2008v2) combining the key learning from 'Lean', 'Theory of constraints' and 'Clinical system improvement'.

1. Focus on the whole patient pathway
2. Plan ahead along all stages of a patient's pathway
3. Balance capacity and demand
4. Pool similar work together and share staff resources
5. Keep things moving—see and treat patients in order
6. Reduce things that do not add value to patients
7. Keep the flow—reduce unnecessary waits.

I then used the NHSI Indicator Explorer tool²⁶ to explore the 'NHS Better Care Better Value Indicators' which can help Trusts with planning, to inform views on the scale of potential efficiency and quality gains in different aspects of care and generate ideas on how these can be achieved. It allows Trusts to export data down to the specialty/procedure level to use in their local analysis and planning, it supported bench marking and nationally defined peer groups for comparison

It can be found at www.productivity.nhs.uk *'Better Care Better Value indicators identify potential areas for improvement in efficiency which may include commissioners re-designing and shifting services away from the traditional setting of the hospital and out towards community based care.*

The tool should prompt you to start thinking of "how" and "why" your organisation might differ from others and to support commissioning priorities for health communities. The opportunity is indicative only and local health communities should interpret it taking into account local knowledge.'

The screen shots from the NHSI Indicator Explorer tool taken in 2007 indicated some of the challenges for this Trust:

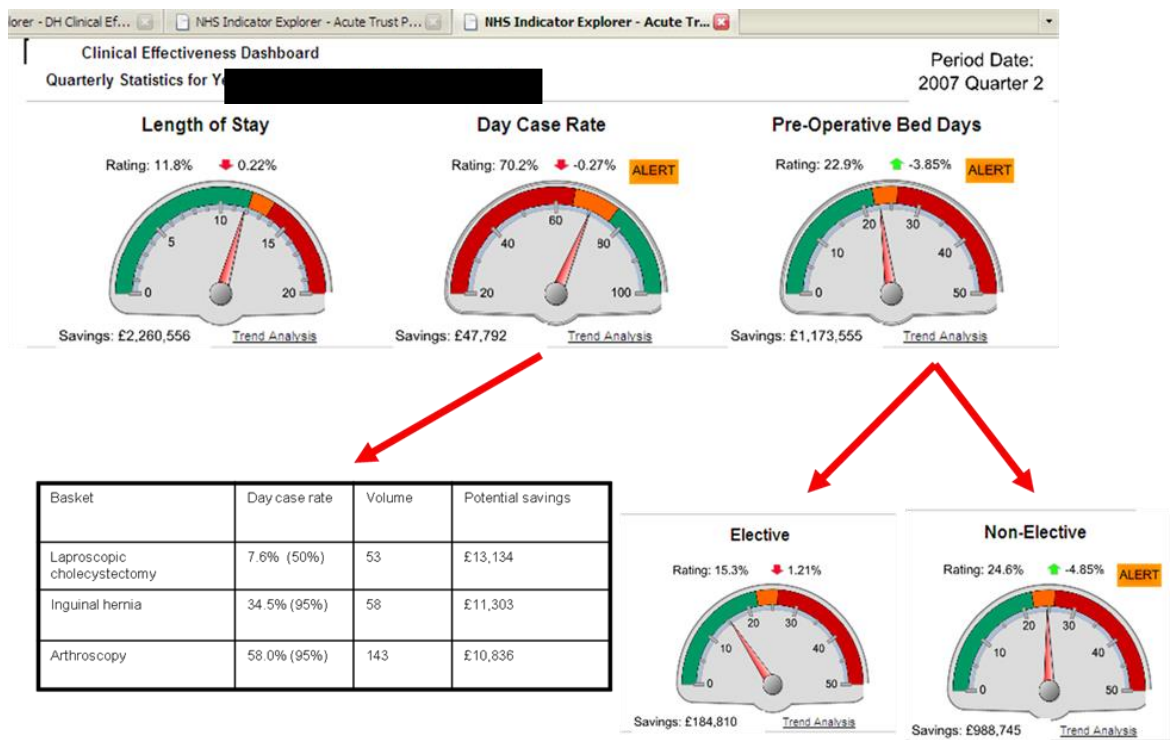
Green on the scale is the top quartile of performance of all Trusts, **amber** is middle 50% quartiles, **red** is the lowest quartile

1. Pre-Operative rate – showed out of 100 bed days for surgical patients 23 days are spent waiting for surgery (their elective procedures were acceptable and their non-elective procedures could improve). This meant there was a potential to improve the use of bed capacity by 23% - although it would never be 0% of patients admitted on the day of surgery for some clinical reasons. This indicator is the pre-procedure length of stay. It is

²⁶ http://www.institute.nhs.uk/news/quality_and_value/nhs_indicator_explorer_-_excel_data_export_now_available.html

expressed as the sum of all the bed days between the date of patient’s emergency admission and the date of their primary procedure divided by the number of hospital spells. A reduction in pre-operative bed days by means of rapid pre-op assessment once admitted, protocols and local diagnostic work-up will help reduce acute bed days. Such pre-operative assessment (POA) and planning, ensures that the patient is fully informed about the procedure and the post-operative recovery.

2. They were using their theatre capacity at 100% theatre for non-day case patients. It was recommended it was used at 80% theatre usage to allow for some variation in patients otherwise the result is cancellations, one of the problems this Trust was now experiencing.



Looking at the DH and explorer tool data (all publically available data at the time) I asked the Trust Board: ‘I wonder if achieving 18 week is affecting your ability to manage your non-electives, thus increasing cancelled operations?’ and I suggested further data to consider, as described on page 173.

This enabled the Trust to really understand what was going on and the areas to focus their attention. Teaching them to use their data gave them the insight to address their own problems.

I made a number of recommendations:

Key steps to reduce their pre-operative days:

- Monitoring the number of days between admission and operation for key groups of emergency patients, such as orthopaedic patients.
- Identifying those surgical specialties where the time to surgery is out of line with peers.
- Review procedures for assessing, stabilising and scheduling emergency admissions for surgery to minimise delays.
- Designing processes to assess emergency patients as fully as possible prior to admission rather than admitting patients to assess them.
- Having assessment facilities located within specialty areas is an effective way of achieving this.

I also shared a model that might help them in their thinking about their challenges:

Diagnosing what's missing: Managing complex change

Vision +	Skills +	Incentives +	Resources +	Action Plan =	Change
	Skills +	Incentives +	Resources +	Action Plan =	Confusion
Vision +		Incentives +	Resources +	Action Plan =	Anxiety
Vision +	Skills +		Resources +	Action Plan =	Resistance
Vision +	Skills +	Incentives +		Action Plan =	Frustration
Vision +	Skills +	Incentives +	Resources +		Treadmill

Adapted from Ambrose, D. (1987)

Coaching the Trust Board through this model revealed it was the improvement skills that were lacking in the organisation.

Looking again at the chart of tools I recommended.

The [highlighted](#) ones did not relate to a particular product produced by the NHSI but to descriptions of service improvement tools and techniques which at this point in time were collated on the web tool the No Delays Achiever.

Cancelled Operations

1. Root Cause Analysis
 - a. Look at the data first
 - i. [\(No Delays Achiever data \(NDA\), Better Care Better Value Indicators, explorer tool\)](#)
 - b. [5 Whys \(NDA\)](#)
2. See the No Delays Achiever for;
 - a. [Cancelled Operations Service Improvement tool](#)
 - b. Planning and Management
 - i. [NDA Improvement Guide](#)
 - ii. [Stakeholder analysis](#)
 - iii. [Clinical engagement](#)
 - iv. [Glenday Sieve](#)
 - c. Diagnose and Analyse
 - i. [Cancelled Operations Diagnostic tool](#)
 - d. Improve Theatre Operating Performance
 - i. [Pre-op assessments](#)
 - ii. [Process Templates](#)
 - e. Scheduling
 - i. [Process Templates](#)
 - ii. [Process Mapping](#)
 - iii. [Identifying the essential resources](#)
 - iv. [Analysing Constraints \(Theory of Constraints\)](#)

Organising for Quality: Delivering Improvement Development Programme

Programme Overview

It can be found at:

<http://www.institute.nhs.uk/images//2011%2010%2004%20%20O4QV%20%20Programme%20Overview%20for%20%20Web%20site%20v2.pdf>

Aim of the Programme

Service Improvement Foundation Programme

A development programme which aims to enable participants initiate, progress and work towards completing a service / project through the development of their service improvement skills and knowledge supported by range of tools and products from the NHSI. A practical development programme of service improvement:

Programme Purpose

- Integration of participants specific projects with their organisations quality agenda
- Enabling participants to deliver specific quality improvement project(s) against their organisations challenges
- Provide participants with individual learning and personal development so that they can support service improvement in their organisation
- Delegates are supported throughout by a programme facilitator.

Programme Elements

Participants have:

- An identified service project to deliver through the course of the 3 month programme
- An executive / senior sponsor to support them in project delivery and use of new skills & techniques

- Five separate days learning the fundamentals of service improvement - supported by NHSI learning resource work books, tools and techniques
- Support of an NHSI programme facilitator who enables progression of local projects through consolidation of the learning and application of improvement skills and techniques.

Programme Introduction

- Style of training is interactive
- Using knowledge and expertise of participants
- Modules are building blocks & each module will integrate
- The tools and techniques used throughout include latest principles from both industry and healthcare
- Designed to equip participants with transferable knowledge
- Refresh current knowledge.

Five-Day Programme

- Day 1 Leading Improvement
Project Management
- Day 2 Sustainability
Engaging Others
- Day 3 Process Mapping
Creativity for Improvement
- Day 4 Measurement for Improvement
- Day 5 Demand and Capacity

Module Details:

Leading Improvement; Aims and Objectives

Aims

To have a greater knowledge and understanding of leading improvement in your organisation.

Objectives

- To identify successful factors to leading improvement
- To identify key qualities needed for service improvement leaders
- To identify the factors affecting change
- Identify need to change

Headline Content:

Explorations of issues which influence how improvements / quality are lead.

Establishing the importance of strategic links to improvement projects

Module in more detail...

- Leadership fundamentals
- NHS Leadership qualities framework
- Is leading improvement different?
- 3 factors of mainstream improvement
- Why change?
- Pressure and challenge facing the NHS
- The case for change
- Why don't good ideas just happen?
- 4 Improvement factors
- Mind-set changes – 'from....to....'
- Sharing problems, not solutions
- Aligning improvement and vision
- Supporting change –8 step framework

Project Management; Aims and Objectives

Aims

Develop a greater understanding of managing successful projects

Introduce the six-stage project management guide

Objectives

- Explore the role of Plan, Do, Study, Act (PDSA) in projects
- Provide a framework for managing projects
- Explore some of the stages and steps in more detail
- Identify relevant tools to use in project management
- Signpost further resources and information.

Headline Content:

Introduction to the principles of project management with some practical tools to help with local projects. More detailed exercise on PDSA.

Module in more detail...

- PDSA cycles
- PDSA tower exercise
- Six stage project management guide & resources
- SMART goals
- Project charters
- Project gateway criteria
- Project barriers and risk

Sustainability; Aims and Objectives

Aims:

- Explore “what is sustainability?”
- Identify what can be done before, during and at the end of a project to ensure and maintain sustainability
- Introduce the NHSI Sustainability Model and Guide

Objectives:

- Apply the sustainability Model to your project
- Identify project priority areas for sustaining improvement.

Headline Content:

Understanding the factors effecting sustainability of projects. Using the Institute's tool in relation to participant's projects.

Module in more detail...

- Project sustainability evaluation study results
- Sustainability frustrations
- Six key considerations for sustainability success (results of NHSI study)
- NHS Sustainability Model & Guide

Engaging Others: Aims and Objectives

Aims:

To improve the outcomes and sustainability of your service improvement by working effectively with your stakeholders

Objectives:

To understand how to:

- Identify your stakeholders
- Manage effective communications
- Gather, understand and use others. perspectives
- Recognise behaviours linked to dealing with change

Headline content:

Use tools to identify the key stakeholders in local projects and how to manage the way you communicate with them.

‘9Cs’

Module in more detail...

- Identifying, categorising and prioritising stakeholders
- Stakeholder communication
- Engaging others
- Engaging clinicians
- Patient perspectives
- Human dimensions of change
- Change adoption
- Change vs. transition
- Managing transitions
- Resistance to change

Process Mapping: Aims and objectives

Aim:

Provide you with an awareness and experience of ‘Process Mapping’ and supporting tools.

Objectives:

- Understand application and limitations of process mapping
- Present different ways to process map
- Detail skills and competencies to facilitate a process mapping session
- Provide an opportunity to ‘have a go’.
- Provide further detail on the next steps after mapping

Headline Content:

Using stakeholder analysis from previous day to bring together project teams to think about the questions asked when mapping with teams and what happens after to create a culture of ownership, responsibility and accountability.

Module in more detail...

- What is a process map?
- What can I map and what will it do for me?
- Current state mapping
- Change magnitude considerations
- Points on 'facilitation'
- Mapping practicalities
 - who,
 - how,
 - materials,
 - symbols and
 - data
- Future state mapping

Creativity for Improvement; Aims and objectives

Aim:

To provide you with an awareness and experience of creative thinking and supporting tools.

Objectives:

- Highlight the need for creative thinking for improvement work
- Explore some of the concepts behind creativity
- Try out some creativity techniques to better understand problems and to generate ideas for improvement
- Signpost resources to use in your own projects.

Headline Content

Building capability, knowledge and skills in both innovation and improvement in order to tackle our challenges. Using some creativity techniques typically used in innovation processes and learning how to apply them to improvement projects

Module in more detail...

- Creativity in the six project stages and the 'model for improvement'
- Finding change ideas
- Mental Valleys
- Using creative techniques to explore problems more deeply
- Through the eyes of... observation exercise
- Using creative techniques to generate new ideas for improvement
- Mental benchmarking
- Harvesting ideas
- Testing new ideas small scale

Measurement for Improvement; Aims and Objectives

Aims:

- To have a greater knowledge and practical understanding of data collection and analysis
- To understand and apply project financial justification measures

Objectives:

- Understand how to do 'real' analysis
- Use data to improve decision-making and identify real improvements
- Develop a project "Business Case" justification by using Return on Investment (ROI) methods and measures.

Headline Content:

Making the How to measure in quality improvement projects more practical and clear. Building on this expanding the learning and approaches to incorporate stronger evidence within business cases through development of ROI evidence

Module in more detail...

- 7 steps to measurement
- Driver diagrams
- Data collection
- Variation in analysis
- Fishbone diagrams
- Run charts / SPC charts
- Trends
- Special causes
- Building the business case
- Return on investment.

Demand & Capacity; Aim and objectives

Aim

To have a greater knowledge and understanding of demand and capacity management.

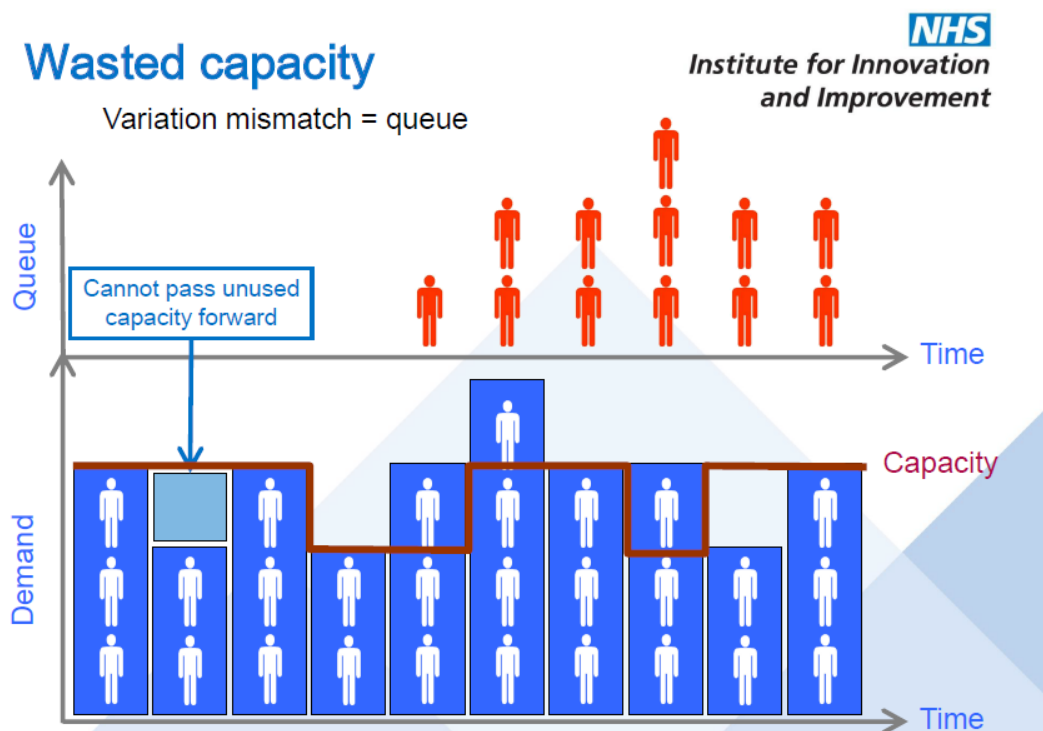
Objectives

- Identify why managing demand and capacity is important
- Understand the importance of using good info in the right context
- Learn about key definitions
- Understand the common reactions to managing backlog
- Understand the importance of measurement
- Identify what you could do differently
- Apply theory to demand and capacity simulation exercise.

Headline Content:

Expanding the learning from measurement and giving practical workshop to apply the theories and principles of management demand and capacity in a scenario activity.

Wasted capacity: Variation mismatch = queue, see diagram:



FAQ

What is the product?

A development programme which includes 5 specifically designed days of core/fundamental service improvement learning supported by 10 days of programme facilitator expertise.

What is the target audience?

Clinical and non-clinical staff involved in service improvement / projects across NHS services. The programme delivers the fundamentals and gives practical application of tools and approaches to initiate and delivery a service improvement project.

What is the target size of audience?

Each cohort is for 20 participants.

What is the lead in time to run the programme?

You need six to eight weeks lead-in time so clinical staff can book out time.

During this period you need to also establish which projects and who will be the executive sponsor / senior lead to help participants sustain their projects.

What is the length of the programme?

- To support project progression the five days of direct delivery is scheduled over three months.

How to get the best from the programme

- There is a nominated executive / senior sponsor at a local level who supports selection of participants what projects
- Participants understand expectations for project delivery
- Local organisation holds event after delivery to celebrate and share participants' project's progress
- Can use learning contracts.

Appendix 20

Feedback from the Pilot Site Trusts on Organising for Quality and Value Programme

"I have been particularly struck by the depth and quality of the programme which has radicalised the approach to improvement that the participants now take and the leadership and professionalism of those from the Institute who have worked alongside us. The depth and quality of the development radicalised our approach to improvement... it has helped accelerate our transformation agenda at a far greater speed than would otherwise have been possible. Saving per patient of £316,750 a project focused on children in intensive care who didn't need to be there".

Sarah-Jane Marsh Chief Executive Birmingham Children's Hospital NHS Foundation Trust. March 2009

"...this has been a very successful venture with the Institute. We now have a much deeper understanding of how to approach improvement in the Trust and what we need to do to be more effective. As a result of this work we are now in the process of implementing a coherent service improvement strategy. The programme has been very well received; staff have both enjoyed and been challenged. The programme was delivered by experts in a very accessible and professional manner.... We would like to purchase more to run 3 programmes a year..."

Gavin Boyle Chief Executive Yeovil District Hospital April 2009


"This five-day programme is a timely offering from the NHSI. It is well structured, highly interactive and jam packed with tools and ideas for achieving success at each stage of the improvement process. It offers participants the knowledge and opportunity to develop their leadership and improvement skills appropriate to the current requirements of leaders in the NHS today. As knowledge and skills are gained on each of the five days, participants are encouraged to apply their learning through practical application as they progress their current improvement projects. This is supported by telephone coaching by the course facilitators.

At Imperial we offer the programme to managers at all levels and across all disciplines to achieve a culture of improvement and build capability across the Trust".


Debbie Bowey, Head of Leadership Development, Imperial College Healthcare NHS Trust


A Step By Step Guide to Tackling Your Challenges

Contents	
Improvement Skills	Core service improvement skills Engaging others
Improving access capacity	01 Demand and
Quality of service	02 Pathway redesign 03 Planned care 04 Unplanned care 05 Theatres 06 Wards 07 Outpatient department 08 Diagnostics 09 Community care
Optimising capacity	10 Surgical thresholds 11 Follow-up ratio 12 DNA rate 13 Cancelled operations 14 Admission avoidance 15 Length of stay 16 Day cases 17 Pre-operative bed days
Patient safety	18 Patient safety – acute care focus 19 Patient safety – primary care focus



A Step-by-Step Guide to
Tackling your Challenges





Foreword

Anyone involved in treating patients, managing and/or improving health services or managing and training those that do, will understand the importance of **providing the best possible care** for all our patients.

High Quality Care for All has really helped to unite clinicians and managers around the principles of quality and value and to focus efforts on using innovation to drive up both the quality of patient care and the **productivity of healthcare services**.


Great progress has been made in improving service standards and access and in reducing waiting times, but there is still some way to go to ensure consistently high standards of patient care across the NHS.

One of the difficulties facing NHS staff is being able to quickly and easily identify relevant quality and service improvement tools and techniques to help implement and sustain changes to services that will ultimately **improve the patient experience**.

We have therefore worked closely with colleagues across the NHS to identify some of the **key challenges that still exist**. We then mapped these against a range of quality and improvement tools and products developed by the NHS Institute for Innovation and Improvement to support the NHS in achieving high quality care for all. The result is this Step by Step Guide to Tackling Your Challenges.

To enable you to access and navigate the full range of products available from the NHS Institute, this guide highlights the **most relevant products and tools to help you tackle the challenges you face**. These range from core service improvement tools that will help you get the basics right, through to using some of the more comprehensive products and services that the NHS Institute has to offer.

I hope you find this guide useful in improving the quality and productivity of healthcare services you provide.



Julia RA Taylor
Programme Director, Organising for Quality and Value

www.institute.nhs.uk 1

It can be accessed at: http://www.institute.nhs.uk/index.php?option=com_joomcart&main_page=document_product_info&products_id=682&cPath=89

Evidence of Public Impact of the iLinks programme:

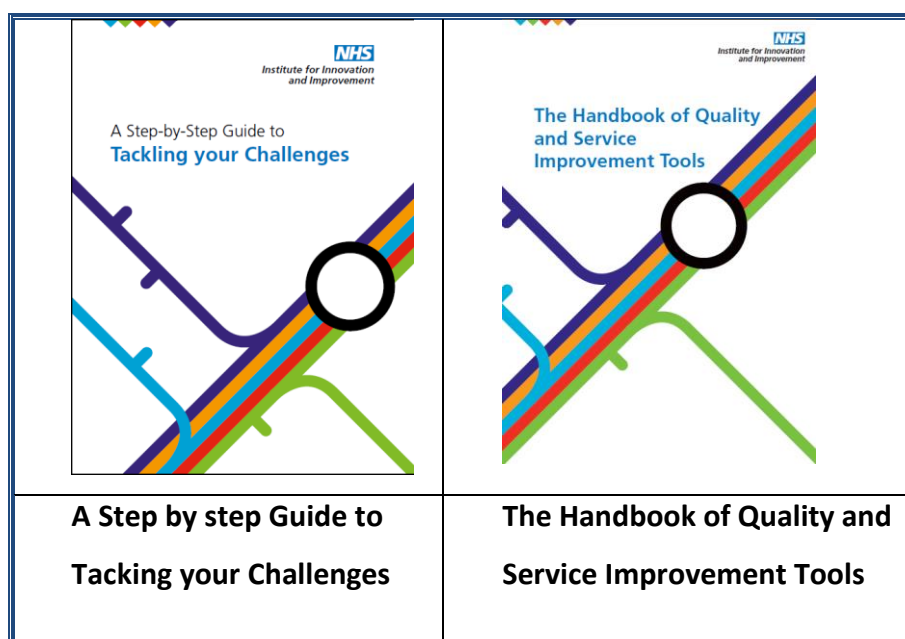
1. The development of the educational programme Organising for Quality and Value to skill up staff to become practitioners of service improvement tools with supporting materials.

The Organising for Quality and Value programme has been running since 2008.

From October 2010 to July 2011 we ran 39 programmes and since the NHSI started charging for it in July 2011 fifty-six cohorts have been delivered at £25K each = £1.4 million income for the NHS. It was also sold and delivered internationally to NHS Scotland and to the Department of Health in New Zealand.

Organising for Quality and Value programme has a series of 7 resource books to support the programme of delivery, covering topics from Demand and Capacity to Process Mapping. The trainers have slides set for each of the taught sessions with speaker notes and they undergo an assessment process to ensure they are fit for purpose.

2. **Publications:** (authored and/or edited by me);





3. Accumulation of Learning

The outcome of the No Delays and iLinks work has been to produce a suite of products branded the **Fundamentals of Quality Improvement**.

http://www.institute.nhs.uk/no_delays/introduction/fundamentals_for_quality_improvement.html

A Description of Commissioned Research using Innovation Cycles

Innovation cycles are a rapid way to research areas of innovation; to create new insights and enable us to affirm or discredit trends and developments which are on the margins of current thinking, but may impact significantly in future.

This innovation cycle represented the initial stage of an innovation/design process, the “opportunity recognition” phase. It had focussed on four strategic questions:

1. What is the size of the opportunity to build system-wide improvement capability, both in the NHS and other health and care systems (considering the global market for capability building)? How should this be defined and quantified?
2. How is learning delivery changing, and what impact is this having on organisations? How can we enhance healthcare improvement capability using the latest virtual methods?
3. What are current approaches to the development of skills and knowledge for job performance, and how can these be applied in the context of NHS transformation?
4. What role can social media play in this reconceptualisation?

The innovation cycle involved scanning the literature, building case studies and conducting interviews with knowledgeable individuals to help answer the questions. It has used a hindsight/insight/foresight methodology:

- what *hindsight* can we gain from the available evidence?
- what *insight* does it give us about the opportunity that is available to us to build capacity for improvement and innovation at scale?
- therefore, what *foresight* does it give us about what we should do in future?

‘Leading Large-scale Change Programme’ Curriculum

The programme covered:

LARGE-SCALE CHANGE model <ul style="list-style-type: none"> - The definition of LARGE-SCALE CHANGE - The model and narrative - The differences to ‘normal’ change - Emergence and influence 	Compelling visions <ul style="list-style-type: none"> - The need & role of the vision - Positioning mission / vision / objectives - Vision examples - The process of vision creation - Doing & being, straplines
Polarities <ul style="list-style-type: none"> - Understanding their anatomy - Recognising polarities in your work - Polarity challenges in LARGE-SCALE CHANGE - Recognising ‘being trapped in one’ - Reframing resistance 	Public narrative <ul style="list-style-type: none"> - Story of now (linked to vision) - Story of me - Story of community
Leadership in LARGE-SCALE CHANGE <ul style="list-style-type: none"> - Positioning leadership models - Defining LARGE-SCALE CHANGE leadership - Personal leadership traits - Leadership under pressure - Role modelling 	LARGE-SCALE CHANGE action planning <ul style="list-style-type: none"> - Driver diagrams - Taking two steps down - 30/60 day cycles

-

Mind-set shifts

- Structure/process/pattern thinking
- The Discovery Model
- [Pattern mapping]
- [Thinking differently]

Distributed leadership

- Definitions and challenges
- Spotting and creating
- Supporting & enabling
- Leadership positioning/letting go

Implementation – behaviours

- Transitions (bridges)
- Endings and beginnings
- Leadership challenges

Assumptions, understanding & Trust

- Assumptions (them/us)
- Continuum of commitment
- Methods of understanding
- Framing

Implementation – moving to business as usual

- Driver diagrams and SPP
- Moving to ‘business as usual’
- Prototyping and piloting

Avoiding the plateau

- Spreading and sustaining
LARGE-SCALE CHANGE
- Spotting LARGE-SCALE
CHANGE endpoints

The Evaluation Design for the 'Leading Large-scale Change Programme'

The external evaluation conducted by Institute for Employment Studies was designed to learn from the participant journey over the duration of the programme. Data was collected in four key areas:

- **Individual:** change leadership development, capability, confidence
- **Team:** dynamics, development, enablers, performance, leadership, coaching
- **Project:** impact, measurement, spread, stakeholder engagement, tools used
- **Programme:** impact, content, learning

The evaluation was shaped using multiple approaches:

- **Learning logs:** At the first event participants were given a team learning log and a participant learning diary as an aid to their reflection. These were designed for personal use but also to provide material for participants to draw on for the project case studies and the evaluation.
- **Online surveys:** three online surveys (beginning, mid-point and post-programme) were emailed to participants to capture data at different points in the programme. Items were grouped under the evaluation headings: Individual, Team, Project and Programme and included an open question in each section. The second cohort joined the evaluation from the mid-point survey only.
- **Team leader interviews:** All team leads were invited to give formative feedback on the programme and recommendations on design and content via an individual telephone interview. Six leaders took part in these interviews.
- **Case studies:** Five team case studies were written up to illustrate the transfer of learning from the programme to a live change project.

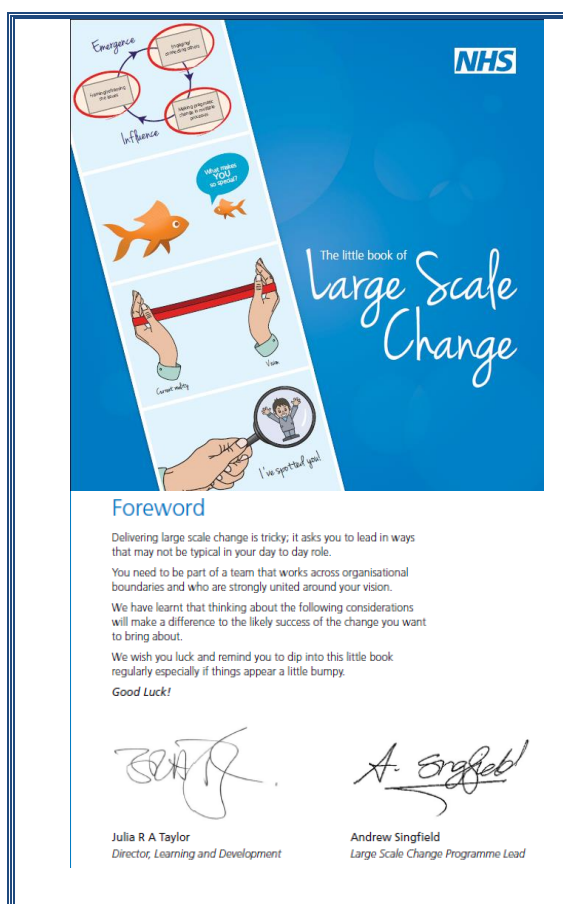
Evidence of Public Impact of the 'Leading Large-scale Change Programme'

1. **Development of large-scale change skills** in 25 senior teams under from across the NHS and associated social care systems, who had undertaken the Leading Large-scale Change programme (over 200 participants).

Following the final workshop participants were asked to describe the key achievements of their projects. These were:

- Shared vision and case for change with multiple stakeholders
- Enhancing service quality
- Reducing harm
- Changing mind-sets and an 'appetite for change'
- Building networks
- Multi-agency and multi-disciplinary working
- Spreading success across regional boundaries
- Having a planned programme of work to deliver large-scale change.

2. **Publication: The Little Book of Large-scale Change** (contributor)



3. Public Narrative:

- Development of learning resources contextualized and relevant to an NHS audience.
- International demand; I have been invited to deliver education and coaching on the skill of 'Public Narrative' in 2012 to Australia, British Columbia and Ireland.

Successes with the Leading Large-scale Change Programme

The workshop format was perceived by the participants as a good blend of theory and practice. It allowed dedicated team time (and project focus) welcomed by these senior and busy people. Face to face workshops allowed good access to the small 'Large-scale Change Teaching Faculty' so we could develop relationships which supported the virtual elements.

The programme materials both edited and built on the work of the past Academy of Large-scale Change which was experimental in nature and rather broad brush. This coherent new 'package' with tight scope and focus was well received and a manageable quantity of learning for the participants as evidenced by the evaluation commissioned. The materials were designed so they had flexibility to adapt to a range of delivery models (e.g. one-day programmes)

Launched before the NHS Change Model (the national NHS framework for change <http://www.changemodel.nhs.uk>) there was good connectivity to it. The programme was designed successfully to be both standardised and mass customised with a healthy blend of cohort and team focused work. The coaching allowed customisation and participants described breakthroughs and momentum achieved through the coaching. A by-product of the programme was a review of the literature (see **Appendix 27** for a sample) and a selection was made available for the participants. (See **Appendix 28** for the papers reviewed made available to the participants). This combined with delivery of the content with others led to a coherent understanding of the theory of large-scale change and understanding of the latest literature that related to delivering large-scale change by myself and the

small teaching faculty. The literature review informed the content of the workshops and webinars.

The evaluation conducted by the Institute for Employment Studies stated:

The response to the programme has been extremely positive throughout and participants felt they were still being introduced to new concepts and theories in the later stages of the programme. The majority have felt re-energised by the programme. Participants have also been very positive about the LSC model and associated tools and techniques throughout the programme. One described it as a 'cornerstone'. The most successful element of the programme has been the attendance at the workshops where the content has been highly valued.

Participants' key insights from the programme identified through the evaluation are summarised below:

- The challenges of working across complex organisational boundaries
- The importance of stakeholder engagement with the success of LSC resting on winning the hearts and minds
- The use of the public narrative and personal story to influence others
- The need to get the vision right
- Keeping the momentum and sustaining the change
- That planning is progress and getting things right from the start means less time overall and more likelihood of getting the right result
- Embracing a personal approach to the management of the programme
- The importance of having governance and project management structures in place to maintain the momentum of the project
- The importance of distributed leadership
- Innovation
- Drawing on wider theory to support change at scale.

A Sample of the Large-scale Change literature reviewed to inform the ‘Large-scale Change Programme’ curriculum

From the field of education policy:

Wheatley, M.J. & Frieze, D. (2007) How large-scale change really happens:

Working with emergence. *The School Administrator*, Spring 2007.

Downloadable at <http://www.margaretwheatley.com/articles/largescalechange.html>

The section entitled ‘Working with emergence to foster change’ describes an approach to large-scale change.

From the organisational development and leadership field:

Keller, S. & Aiken, C. (2008) The inconvenient truth about change management:

Why it isn’t working and what to do about it. *McKinsey Quarterly*, June.

Describes both successful and failed large-scale change efforts across a variety of settings.

From environmental studies and the complexity and systems thinking literature:

Gunderson, L.H., Holling, C.S. (eds.) (2002) *Panarchy: Understanding Transformations in Human and Natural Systems*. Washington DC. Island Press.

Features papers and case study examples from some of the leading names in the emerging study of ‘panarchies’; the interaction and change process in systems embedded within larger systems.

From healthcare:

Oldham, J. (2009) Achieving large-scale change in healthcare. *Journal of the American Medical Association*, 301(9): 965-966.

From social movement thinking:

Ganz, M. (2010) Leading Change: Leadership, organisation and social movements in N. Nohria and R. Khurana (eds), *Handbook of Leadership Theory and Practice*, chapter 19. Massachusetts: Harvard Business School Press.

Describes a model of organising leadership for change at scale.

From the field of government policy:

Best, A., Saul, J., Carroll, S., Bitz, J., Higgins, C., Greenhalgh, T., Lewis, S., Bryan, S. & Mitton, C. (2010) *A Systematic Realist Review and Evidence Synthesis of the Role of Government Policy in Coordinating Large System Transformation*.

Vancouver: Coastal Health Research Institute.

Identifies how governments can put in place the contextual and enabling factors for large system transformation.

‘Leading Large Scale Change Programme’: Literature review resources made available to the participants

These can be found at

http://www.institute.nhs.uk/leading_large_scale_change/members_area_%e2%80%93_leading_large_scale_change_support/additional_resources.html

Case Studies

This [recording](#) and slides from Phil Da Silva (Joint Lead for RightCare) and Matthew Cripps (Improvement Director) describe their experiences of delivering large-scale change across systems seeking to deliver significant financial savings. More information about the RightCare programme which aims to increase value in the NHS for patients and commissioners can be found at www.rightcare.nhs.uk

This [link takes you to a recent talk by Ken Kizer](#) at a King’s Fund conference on ‘integrated care’. Ken is talking about his work as former Under Secretary for Health at the US Department of Veterans Affairs (VA) where he was widely credited with turning around the VA health care system. This talk is illuminating as many of the key principles that Ken describes reflect aspects of the LSC approach discussed during the programme.

Leadership

This section contains materials that come under the broad heading of ‘leadership’ in the context of transformational change.

- Plsek, P. (2009) *Four Venues of Leadership: Insights for leaders of large-scale change*. NHSI.

Describes four key areas that leaders need to pay attention to as they seek to deliver transformational change.

http://www.institute.nhs.uk/images/Large_Scale_Change/Four%20Venues%20of%20Leadership%20by%20Paul%20Plsek.pdf

- Collins, J. (2001) Level 5 Leadership; The triumph of humility and fierce resolve. *Harvard Business Review*, January, 67–76.
Describes the behaviours seen in leaders who are recognised as helping their organisations make the leap from good to great.
- Goleman, D. (2000) Leadership that gets results. *Harvard Business Review*, March/April, 78–90.
Describes the range of leadership styles that have been found to be effective when adapted to specific circumstances.
- The Welsh NHS Confederation, *Review: Managing transitions by William Bridges*, www.welshconfed.org,

Complexity Theory

The series of papers below by Paul Plsek and other authors describes how complexity science is relevant to healthcare.

- Plsek, P. & Greenhalgh, T. (2001) The challenge of complexity in healthcare. *British Medical Journal*, 323, 15 September, pp. 625–628.
The challenge of complexity in healthcare and its overview introduce the key features of complex adaptive systems in the context of healthcare.
- Wilson, T. & Holt, T. (2001) Complexity and clinical care. *British Medical Journal*, 323, 22 Sept, pp. 685–688.
Complexity and clinical care and its overview draw lessons about complexity from clinical examples.
- Plsek, P. & Wilson, T. (2001) Complexity leadership and management in healthcare. *British Medical Journal*, 323, 29 Sept., pp. 746–749.
Complexity leadership and management in healthcare organisations and its overview moves the emphasis to the role of leadership and management in creating change.

- *Pattern Mapping Workbook: Mapping Behavioural Patterns, exploring the underlying factors that accelerate or impede system transformation.*

Modernisation Agency 2005

The pattern mapping workbook describes some of the common patterns found in organisations that are known to inhibit transformational change. It offers a range of techniques for understanding and altering these patterns.

Public Narrative and storytelling

- Denning, S. (2004) Telling tales. *Harvard Business Review*, May, pp. 1–8.

This describes how the age-old practice of storytelling is one of the most effective tools leaders can use. But they need to pick their stories carefully and match them to the situation.

- Taylor, J.R.A. (2012) *A 'Narrative For Change'; Galvanising Shared Values* (adapted from Ganz 2010)

This workbook describe the framework and skills needed to deliver a public narrative successfully.

Large-scale Change Theory

- Keller, S. & Aiken, C. (2008) *The Inconvenient Truth about Change Management*. McKinsey and Company.

http://www.mckinsey.com/App_Media/Reports/Financial_Services/The_Inconvenient_Truth_About_Change_Management.pdf

This paper introduces the conventional (and correct) wisdom on how to change employee attitudes and behaviours whilst simultaneously challenging the way many organisations implement this wisdom. The central point they make is that although we all know what we need to do, our intuitive attempts to put this into practice are often wrong.

- NHS Institute for Innovation and Improvement (2009) *Inspiring Change in the NHS: introducing the Five Frames*. Coventry: The NHS Institute for Innovation and Improvement.

This document introduces NHS leaders to the Five Frames, as they consider what changes may be needed in their parts of the system, and how they can achieve them.

The Five Frames are: Performance & Health:

Change is not just about delivering performance today. It is also about creating 'healthy' organisations and systems which will deliver performance tomorrow and the day after.

The Discovery Process:

Creating deep, sustainable change is not just about creating an excellent strategy or about redesigning delivery systems and processes. It is also about changing the mind-sets which underlie behaviours and outcomes.

The Influence Model:

When we plan actions to bring about the desired changes in mind-sets and behaviours in our organisations, we need to make sure that we create a wide range of initiatives that cover a broad perspective of change, rather than concentrating on a single 'type' of intervention that will not deliver wide scale change.

Change Architecture:

In designing a change strategy, particularly in a complex system, we need to plan carefully to make sure that the initiatives are well-sequenced, occur at the right place in the organisation, engage stakeholders and are well-understood.

The Benefits Hierarchy:

Measuring the success of change interventions is vital. As well as ensuring that initiatives are on schedule and milestones are met, and measuring performance as the outcome, we need to measure organisational and system health and make sure it is improving.

Systems Thinking

- Ernst, C. & Chrobot-Mason, D. (2011) Flat world, hard boundaries. How to lead across them. *MIT Sloan Management Review*, Spring, 8–88.

This paper offers an interesting exploration of how to span boundaries between teams or organisations. Whilst not directly focusing on large-scale change, it provides insight into some of the 'boundary' problems we often encounter and seek to remedy through large-scale changes (e.g. transforming community services). It is therefore particularly relevant to anyone looking towards integration or restructuring as a solution to system problems.

The major learning point from this paper is the description of a series of sequential sets of activities that build towards what the authors call the 'nexus effect'. These steps offer a practical process for gradually building alignment between parts of a system.

Other useful readings are

- Capra, F. (2002) *The Hidden Connections: Integrating the Biological, Cognitive, and Social Dimensions of Life into a Science of Sustainability*. New York: Doubleday.

Large-scale Change Team Application Form

It can be found at

http://www.institute.nhs.uk/images/Large_Scale_Change/09_05/LSC%20support%20programme%20April%202012%20application%20form.docx

Large-scale Change Team application form

This form should be completed in consultation with the participating team members and the project sponsor. Email the completed form to LargeScaleChange@institute.nhs.uk. Advice on completing the form can also be requested via this email address.

SECTION A: Participating team

This programme is open to teams of 2–6 people. Please give the individual details below.

The first named participant will be treated as the main contact point for further information.

Main contact – Team member 1	
Name	
Job title	
Organisation	
Email address	
Work contact number	
Team member 2	
Name	
Job title	
Organisation	
Email address	
Work contact number	

Team member 3	
Name	
Job title	
Organisation	
Email address	
Work contact number	
Team member 4	
Name	
Job title	
Organisation	
Email address	
Work contact number	
Team member 5	
Name	
Job title	
Organisation	
Email address	
Work contact number	

Team member 6	
Name	
Job title	
Organisation	
Email address	
Work contact number	
Name	

What level of support are you applying for? <i>(please indicate with an x)</i> Both subsidised	
Main LARGE-SCALE CHANGE support programme only (£9,995)	
Main LARGE-SCALE CHANGE support programme and 'next steps' support (£14, 990)	
Which organisation will be paying for this programme? <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	
(Note: If your team is being provided with a place on the programme by a sponsoring agency such as your SHA, please still indicate the level of support and give the details of your sponsoring agency.)	

SECTION B: Team sponsor

Please give the details of your team sponsor. Note that your sponsor will be expected to attend some sponsor specific elements of the programme and we strongly encourage sponsors to be a full part of the project team.

Name		
Job title		
Organisation		
Email address		
Work contact number		
<i>(please indicate with an x)</i>		Yes
Is this person an executive director?		
Will this person be a core member of your project team?		

SECTION C: Project information

Please give us some background on the large-scale change project that you intend to undertake.

Title of the project
Main objectives and scope of the project
Key organisations likely to be affected by the project
Background to the project (e.g. some of its history and progress to date)
Project related background on the team (e.g. indicate if the team members applying for the support programme already work together as part of an existing team and how frequently you meet)

Section D: Project assessment

In order to help your team consider your project in light of some of the principles we will be exploring in the programme, please answer the following questions.

We suggest that you discuss these questions as a team.

B: LARGE-SCALE CHANGE typically involves creating coordinated changes in 'structures, processes and patterns'. Patterns refers to outcomes, behaviours, relationships, how decisions are made, power etc.

What are the key structural changes that you think are required?

What major processes will need to change?

What would you hope to observe in terms of new patterns (e.g. new behaviours in the system)?

C: In LARGE-SCALE CHANGE there are likely to be many different stakeholder groups , each motivated by their own reasons to engage with (or reject) the change.

Who are the key stakeholder groups in your change and what is it that would encourage them to accept and support the changes you envision?

(Note: you may want to consider involving some of these stakeholder groups through representatives on your project team)

D: All large-scale changes require multiple actions across multiple areas. We sometimes describe this as 'lots of lots'.

Between now and the end of April, what are the main actions that are planned in relation to your project?

E: LARGE-SCALE CHANGE projects always exist in some form of local context that may help to enable change (e.g. a culture where learning from failure is encouraged) or prevent change (e.g. poor sharing of ideas across the system).

What do you think are the key enablers that you, your sponsor and the people you can influence need to put in place to help make your project a success?

(Note: This question is not simply asking you for your project risks. It is asking you what you believe should be done to make change more likely)

Please email the completed form to: [REDACTED]

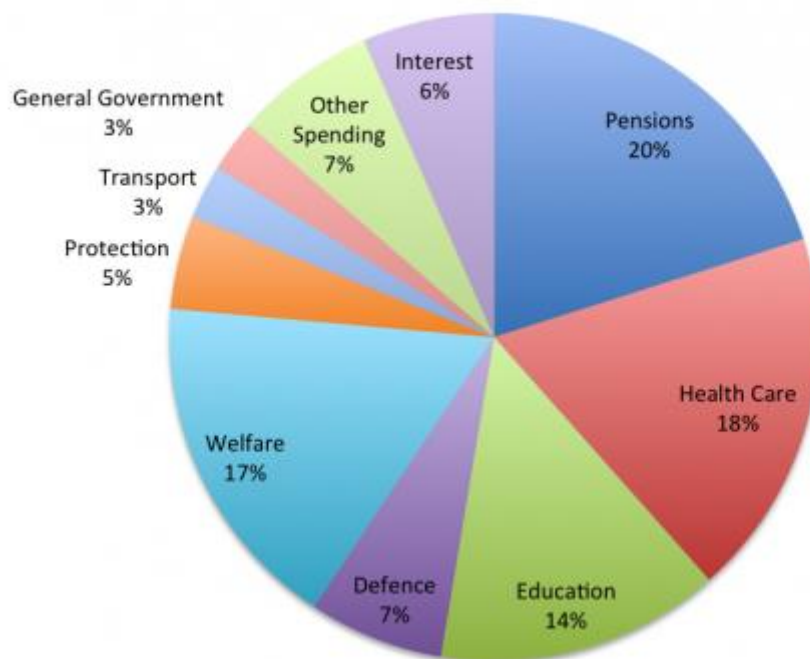
Appendix 30

Government spending as % of GDP

<http://www.economicshelp.org/blog/5326/economics/government-spending/>

Accessed 2nd April 2013

UK Total Government Spending 2013



www.economicshelp.org | Source: UKpublicspending.co.uk